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BRINGING HOME THE BIENNIAL

Now that the California Biennial recedes to only a golden memory, the problems of *how to enjoy a professional convention* suddenly become insignificant compared with the problems of *how to report a professional convention* to the folks at home. We begin to recall various convention reports we have heard, hoping for a pattern to follow. We remember one that gave a vivid, colorful account of the high lights, costumes, and amusing incidents. It entertained the stay-at-homes but brought them little of the real essence of the convention. Another report gave a conscientious but monotonous account of every happening without discrimination as to what was important.

What are some criteria of a good convention report? First of all, it should be *interesting,* with enough local color and human touches to recapture the atmosphere. What impressions stand out from among the myriad of experiences in that crowded week? Do our thoughts rest on the warm, informal hospitality of our hostesses, the background of California sunshine and tropical verdure, the thrill of hearing or meeting people whose names had long been known to us, the sense of solidarity which comes from finding ourselves in a large audience of people with similar purposes and interests? These are the touches that give vitality and realism to our report. But they are, after all, only the setting. What comes next?

Here is the test of our ability to select, to evaluate. Where shall we begin? First of all, what was the central theme, the chief emphasis, of the convention? In this Biennial, the three national organizations decided on the convention theme of Nursing as a Part of Tomorrow's Community Health Service. The N.O.P.H.N. program fitted naturally into this pattern. The panel discussion analyzed the subject of adequate public health nursing in the community, and the round tables almost universally echoed the same theme. The N.O.P.H.N. exhibits showed a blue-uniformed nurse going into homes and schools, conducting a baby conference, giving bedside care—all in the setting of the community.

What, then, was the next step? Public health nursing, though essentially concerned with community needs, works primarily with the family as a unit. The first general session emphasized the importance of the family in society, and the theme of family health work was woven into subsequent meetings. Some of these were concerned with special problems which affect the

health of the family, such as tuberculosis, cardiac disease, and maternity. Others discussed the preparation of the nurse—student and staff nurse—to meet these problems. Still others took up the newly developed federal plans for the solution of such problems under the provisions of the Social Security Act.

Thus far we have retraced the main highway of the convention, which was marked with illuminated signs so that it was hardly possible to miss the road. From this point each individual's interpretation and points of emphasis will depend upon his own interests and background and sense of values.

It is worth while to quote from the suggestions in the February issue on how to enjoy a professional convention. "Don't be disappointed if you don't get new facts. (You won't if you keep up on your reading.) Aim rather for the development of new attitudes, new appreciation of values."* What new attitudes, trends, and values could be drawn out of the many papers, discussions, exchanges of ideas between east and west, north and south?

One that seemed to us frequently recurring concerns the newer concept of human relationships. It stressed the importance of *understanding human behavior* rather than passing judgment on it. Along with this goes an emphasis on a *mutual working together* of executive and staff, nurse and patient to replace the authoritative approach which has permeated nursing all the way from supervisor and staff relationships to nurse and family relationships.

Another trend which seemed to run like a thread through many sessions was the tremendous importance of lay participation, of interpreting public health nursing to the community. This matter of lay understanding becomes constantly more essential with the growing increase in tax-supported services. And emphasized just as frequently was the interpretation of our work to the physician, a relationship in which we have been seriously amiss.

Our profession faces rapidly changing times. Many trends were reflected in the discussions of the Biennial Convention. It is these which make the delegate's report really valuable to the folks at home. We have suggested two or three points of emphasis. You have undoubtedly found many others.

Once there was a nurse who attended a Biennial. Upon her return, she was asked what she had gained from it. She paused and thought. Finally, she said, "Well, to tell the truth, I didn't learn much that was new." Presently, she brightened and said, "Yes, I did learn two new things. One was a new way to put on diapers. The other was a good way to elevate the head of the bed."

We believe you will agree that what we get out of a convention is largely an indication of our own sense of values. Certainly our ability to report it is a challenge to our powers of discrimination, evaluation, and presentation.

*See PUBLIC HEALTH NURSING, February, 1936.

THE NEXT BIENNIAL CONVENTION WILL BE HELD IN KANSAS CITY, MO., IN 1938

TOTAL REGISTRATION AT THE BIENNIAL CONVENTION OVER 5000

A "Board's-Eye" View of the Biennial

By ANNE G. DELLENBAUGH

Secretary of the Board of Directors, Community Health Association, Boston, Massachusetts

ALTHOUGH only one humble splinter, I have ventured to speak on behalf of boards and committees in general, partly because that was the request of our editor, but mostly because my resistance to the lure of even so atrocious a pun seems to be lowered.

Knowing that the keynote of the convention was to deal with a program for the future, the use of the transportation of the future seemed indicated; and accordingly a delightful and comfortable seventeen hours saw me transferred by air from Newark to Los Angeles. Perhaps it was this flight which gave me a particular interest in the competition for a job as "hostess," which one of the transcontinental air lines conducted at the convention. Any graduate nurse who felt she complied with the rigid requirements as to weight, height, and personality was eligible to enter, the final selection to be made from the point of view of charm. From the unbridled mirth which greeted the announcement of the terms of the competition, it did not seem as though many were attending the Biennial with a view to exploiting their charm.

There were few board and committee members present in comparison with the large registration, though ten states were represented. Those of us who did go will never forget the consideration with which we were treated, not only by our hostesses, but by our fellow conveners as well—who seemed to feel that we deserved credit for coming, whereas we ourselves felt privileged to be taking part in such an important gathering.

In summer it never rains in Southern California, so perhaps there was no reason to be grateful for the fine, sunshiny weather which made it possible to enjoy every spare minute in seeing the country with its beautiful mountains and astoundingly lovely trees and flowers.

The weather did treat us to one surprise in the form of a really first-class thunderstorm, which "never occurs in Los Angeles." In spite of its rarity it was rather an anticlimax, as everyone assured us that the preceding ominous darkness betokened an earthquake.

There were several meetings of special interest to lay members, such as the luncheon of the Board and Committee Members' Section of the N.O.P.H.N., a delightful tea given to us by the Pasadena Visiting Nurse Association, and a round table on the Educational Value of Records. Besides these there were the general meetings of the N.O.P.H.N. and the joint meetings with the other two nursing organizations, all of great interest to anyone concerned with public health nursing. The many round tables afforded opportunities for a discussion of problems and an exchange of views among those who were interested in some particular phase of work.

The panel discussion was certainly intensely interesting and amusing to those who took part in it. The skillful guidance given by the chairmen and the eagerness with which all of us aired our views made it a very live meeting. The men of the panel were particularly reluctant to give up the floor, and one of them plaintively remarked that they were being discriminated against by the chairman, who never interrupted any of the women; to which the chairman replied, with one of the best lines of the whole convention, that "the women seem to have better natural terminal facilities."

At the dinner of S.O.P.H.N. presidents and chairmen of public health nursing sections, one point was of extreme interest to all board and committee members. In practically every one of the reports regarding the programs of the 27 states represented, efforts to develop *lay interest* in public health nursing were stressed It made

us feel both proud that the professional group should want our coöperation and fearful lest we should fall short in fulfilling our share of the partnership.

The theme of the convention being Nursing as a Part of Tomorrow's Community Health Service, the question was constantly in my mind, "What will be the function of the board or committee member in the nursing program of the future?" California and much of the West seem to do most of their public health nursing through official agencies, few of which have lay advisory committees. Perhaps the board or committee is a protective element for the transition stage, as the cocoon is for the caterpillar, and will be discarded when the full-grown butterfly emerges. If so, we must be prepared to let go with a good grace. We must watch the course of development and adapt ourselves to it—not try to crowd public health nursing back into the already established patterns. Should economic and social changes do away with the private agency, the job of directly administering a nursing service will be taken out of the hands of the board or committee; in that event it will be the duty of the board to see that the service does not suffer during the transfer, that the continuity is not injured.

Whether administrative work remains partly in the hands of the boards or is wholly taken away from them, there is another unescapable responsibility belonging to all who cherish the ideal of a complete health service for every community. Because of their understanding of this one branch of such a service, those who have served on boards or committees of public health nursing associations must take their places as leaders of public opinion. And to be leaders they must know what the trends of thought and development in the nursing field are, as well as the needs of their section of the country. There is no room for "agency consciousness" in such thinking. Any single agency, whether official or private, is only one means towards the end all have in view—an end the consummation of which can only be delayed by a biased or inflexible point of view.

A nursing service—no matter how complete in scope or excellent in quality—does not exist in a vacuum, but is dependent to a large extent on conditions existing in the community. These conditions the lay advisory committee or administrative board—as informed and interested citizens—must try to modify so that the community health program may have the proper soil in which to flourish.

Both Dr. Eduard Lindeman and Dr. Paul Popenoe emphasized eugenics as an essential for national health. Until the principles involved and the measures—both positive and negative—that may be used to make the principles effective are thoroughly understood by the community as a whole, eugenics can never play an important rôle in the country's development.

Similarly, until the taxpayers and parents are in sympathy with some of the newer principles of education, our schools cannot give the instruction which helps to safeguard the health of the young people and to facilitate their making a success out of marriage and parenthood. Until public opinion really understands the problem of syphilis and gonorrhea, no amount of scientific knowledge, no development of technique for treatment, can make possible an effective program for the control of these diseases.

As far as we can see into the future, these and other similar avenues of endeavor will be open to the layman. Their part in the community health program of the future may be different from what it is today, but there seems to be no immediate prospect of a dissolution of the partnership between the professional and the lay groups.

The Biennial left one with the feeling that the future must be envisaged in broad terms, that each one of us must try to think straight about what is in store and help others to do likewise. Instead of clinging to the old adage that "Whatever *is* is best," we must fix our minds and hearts on the ideal we hope for; and undiscouraged by obstacles, we must believe, along with Dr. Lindeman, that when we all want a certain condition, that condition will exist.

The Biennial in Retrospect

By GRACE FRAUENS, R.N.

Educational Director, Visiting Nurse Association, Kansas City, Missouri

THE Biennial Convention is an event to which many nurses look forward throughout the two years between meetings. In June of this year thousands of nurses traveled hundreds of thousands of miles to attend the convention in Los Angeles. They were lured not only by a desire to visit California, but were seeking knowledge, ideas, and inspiration. Any gathering of nurses, local, state, or national, may serve such a purpose; a convention of the three national nursing organizations cannot fail to do so.

The Sunday afternoon open-air vesper service in tribute to Florence Nightingale was an outstanding event. Those who have not seen the famous Hollywood Bowl should look on page 253 of the April issue of PUBLIC HEALTH NURSING. If you can add to the picture which appears there the following, you will have some idea of the indescribable beauty of the setting for the Nightingale service: a chorus of two hundred nurses in uniform seated in the background; in front of them the officers of the national nursing organizations in colorful afternoon gowns; the band in the center front; American Red Cross nurses in familiar red and blue capes on either side; flags which were kept waving by the breeze; flowers in a semicircle below. Now look at the great white vases nestled among the evergreens and then off to the hills dotted with huge white flowers of the yucca. (True, one could not help smiling at members of the audience who tucked newspapers under hat brims to shade their faces and later, when the sun had disappeared behind the hill, used the same newspapers as shawls.) The tribute to Florence Nightingale was as beautiful as only Miss Goodrich could make it.

If you have not already seen Kay Francis in *The White Angel,* I hope that you will recall this service when you do. Visualize William Dieterle, the director of the motion picture, telling the vast throng of nurses that he greeted them in the spirit of Florence Nightingale; that he was born on the Rhine near Kaiserswerth and first heard of Florence Nightingale there. Then picture Kay Francis—carrying flowers instead of a lamp—telling us that she felt honored to repeat the Florence Nightingale Pledge for us.

Every Biennial has a convention theme but not always is it printed on the program. (The programs were unusually attractive and the thumb index was a great convenience.) The program committee did a splendid job, and the theme, Nursing as a Part of Tomorrow's Community Health Service, was evident throughout. It is difficult to think of any phase of the subject that was not presented. We learned from Dr. Aurelia H. Reinhardt, President of Mills College, what contributions women will be making, with emphasis on their contributions to the health of the individual and the group.* The objectives for an adequate community health service were presented, and many sessions were devoted to a study of the factors involved in providing such a program. The preparation of the nurse for community service, the development of registries and nursing bureaus, and the responsibility of various individuals and groups in the community were ably discussed. Again and again we were reminded that every nurse should be aware of *all* of the problems of nursing.

Many favorable comments were heard about the number of round table meetings included in the N.O.P.H.N.

*Paper read by Esther Dayman, Dean of Women, Mills College, at the Joint Opening Session, Biennial Convention, Los Angeles, California, June 22, 1936.

program. Needless to say it was often difficult to decide which one to attend. The chairmen had well planned meetings and most of the groups were small enough for informal discussion. It was interesting to watch little clusters of nurses, intent on getting as much as possible out of the convention, plan their schedules for the meetings.

As usual there were many special breakfasts, luncheons, and dinners. The Membership Rally luncheon was a rare treat. Imagine having the quintuplets appear on the stage as young women preparing to enter a school of nursing; seeing them after their return; and hearing them tell the dear doctor, now old and feeble, all about nursing in the year 1960 or thereabout. You would never guess all of the changes that were supposed to have taken place. The skit was written and presented by the California nurses.*

Among the many points of interest visited by the convention guests was one which is extremely unusual. (We were told that everything in California is unusual—the weather undoubtedly was.) If you have not seen Forest Lawn Memorial Park, go there the next time that you are in California. More than a million people have viewed "The Last Supper" window. It is a beautiful stained glass recreation of Leonardo da Vinci's painting in Milan. See also the Wee Kirk o' the Heather, which is a reconstruction of Annie Laurie's church in Dumfriesshire, Scotland, and the Little Church of the Flowers, patterned after the one at Stoke Poges in Buckingham, England, where Gray wrote his "Elegy."

Impressions of the convention would be incomplete without a word in regard to activities during the past biennium. Almost a dozen joint nursing committees representing the three national organizations are functioning at present—another evidence of the realization of joint responsibility. As the President of the American Nurses' Association said in her address to the House of Delegates, "The nursing service offered the community must be a coördinated service."

Reports of officers and committees sometimes afford uninteresting reading, but there should be an appreciation on the part of every member of the magnitude of the tasks which have been performed. A sense of belonging to a great professional group, and pride in that group, is experienced by those attending a convention. Without work—constant work—there would be no organization of which to be proud.

The words of the final number sung by the nurses' chorus, "Take joy home and make a place in every heart," were exceedingly appropriate. Those who were privileged to attend the 1936 Biennial did take joy home—not only joy, but also ideas, inspiration, and pleasant memories. Whether or not we carry out the command to make a place in every heart, depends upon how generously we share our experiences with those who stayed at home.

*See "The Quintuplets Become Nurses," page 576.

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Social Planning for Tomorrow

By EDUARD LINDEMAN, Ph.D.
Professor of Social Philosophy, New York School of Social Work, New York, N. Y.

NOW that you have come to the close of this convention I suppose many of you are wondering what precisely has been its advantage and what will be the advantage in the future as a result of this experience. I suppose we all go to conferences on behalf of mixed motives. Certainly the great habit of convention-going in American life, since it includes so many people, must also involve a great many incentives. I am sure many of you have come for the sake of a holiday, and I hope you have had one. I trust also that many of you will have gone back from this convention with some new and renewed understanding or sense of belonging to the group—people who are dedicated to some cause. I hope also that you have learned something new in the technical fields of nursing and medicine. For certainly you must have some reason for coming to this conference in addition to the first two, and therefore you also include in your convention discussions many of the newest discoveries in our related fields.

But after all, the real purpose I suppose of a conference is something more than any of these three; namely, this: We go to conferences primarily for the purpose of attaining a new perspective, of seeing the work which we do day by day, following a routine, in relation to the nation as a whole. For it is only as we come into a sense of perspective that we can also get what it seems to me all of us in this generation so sorely need—a sense of courage. If you do not know where your profession belongs in relation to the future, then your behavior at present will be marked primarily by timidity, even cowardice. And I am not now thinking of you as a professional group primarily. I should say the same of doctors, teachers, preachers, educators, lawyers, engineers—all the professions whose work has been so sadly dislocated during these last five terrifying years. In fact, I prefer to address you as citizens, as persons, as professionally trained people who have, in addition to the normal responsibility to your own science and your own practice and to your patients, the additional responsibility to a public. For whether you wish it or not, the mere fact that you are a professional person in your community means that you are a sort of opinion-maker. What you say about general problems as well as what you say about your own profession carries more weight than that of an untrained person.

I address you then primarily as fellow-citizens, faced with the problem which your convention program has so admirably marked out; namely, what is to be your place in the future and how are you as citizens as well as professional persons preparing the long-time future, the perspective which will ultimately, if it becomes clear, mark out the channel in which this profession is to grow? It seems to me that our problem is not primarily technological. In fact, none of our problems today are especially technical. A century ago, yes. A century ago the great task of the people of this country was to possess this continent, to exploit its resources. What we needed then was human labor, mechanical power, invention, technology, and what we need now is a sense of what these instruments are to be used for.

Our problems are primarily in the area of purpose, will, desire, feeling—yes, feeling. Because it is true, I believe, that you cannot count on social feeling on the part of those who are trained in our American colleges, uni-

*Presented at the Joint Session of the Biennial Convention of the three national nursing organizations, at Los Angeles, California, June 25, 1936.

versities and technical schools. If we only could! If we could only be sure in this country that every young man and woman who had had the privilege of a common school education and higher and professional training, would thereupon be a person suffused with social feeling and equipped with social capacity, ready to play his part in a social world! If we could count on that, most of the evils of our present existence would have been solved long ago. We must learn how to feel, deeply, persistently, about the problems of our fellow-men, or else there are no levers for action.

The three prerequisites for social action, it seems to me, are these: *first, we must learn to think in terms of clarity, simplicity, first principles.* Many of our problems have become complicated. Indeed, many of our citizens have already abdicated, have run away from the problems because they believed them to be too complicated. I warn you, however, complexity is never a quality outside of thought. Problems themselves cannot become too complex. Our minds may become confused and we may mistake such confusion for complexity. The real difficulty is not in the problems but in us, for we have lost the sense of clarity. We do not know how to study our problems in such clear terms as to make meaning, first of all to ourselves, and second, to those over whom we exercise some educational influence.

In the second place, we need to think in terms of design and pattern. For, after all, life only takes on meaning when what we do from day to day fits into the pattern; not a steady pattern, not a completed one, but an evolving, emerging, growing pattern of life. And again, we in America have lost our pattern. We do not know what the America of the future is to be. We do not have in our minds a dream, as our forefathers had—a glowing, inviting dream of a new land, a fresh land, full of zestful people, striving on behalf of what? That which they wrote twice in their Constitution, namely, on behalf of the general welfare. A country in which there was to be welfare for all, in which there was to be a good life for everybody! But we lost that pattern, and so, as the prerequisite to the discovery of our place in a future design for America, a future planning program, we must learn to think in terms of design and pattern.

Finally we need to think in terms of value. The technical problems of our own age can all be solved, relatively at least; but what we need is a sense of the end or the goal of the instruments which we use. Why all these factories, why all this transportation and communication machinery? For what purpose, in terms of what value?

In the light of these three prerequisites of the modern mind, I should like to present to you briefly what seems to me to be a fair, simple, clear, good design for the general welfare of this country, by asking three questions. First, can we as persons whose profession is based upon welfare state our program clearly, directly and simply? Do we know what we mean when we say "welfare"? Second, if we know what we mean, do we have the assurance that this can be achieved in terms of human nature, or is it an impossible and impractical term? And, third, can it be achieved in terms of the material world? Is it possible in the kind of a world in which we live to think rationally, clearly and practically about a world in which everybody shall have a good life? And in the end, of course, we must think—since all these problems tend to become increasingly political in character—in terms of whether or not welfare can be achieved in terms of the American tradition, of democracy or federalism. I shall give quick answers to these questions, answers which perhaps to some of you may not sound wholly judicious. I warn you of that in advance. I do not ask you to follow my conviction; I ask you only to accept it as a challenge to test your own conviction. If I therefore at times seem a bit too sure, that ought to be a sufficient warning to you to increase your critical capacities. I ask you only to believe that what I say, I believe; and I am earnest about it.

I answer those questions in this form.

First, I can be clear about human welfare because it seems to me to divide itself into two complementary programs. First, human welfare means a program of eugenics, in which we strive with all the technical means at our command to bring into existence a good, sound, healthy race of human beings. And thus far we have done very badly, for the American stock gets poorer all the time; it is not as good now as it was fifty years ago, by any test except one, which is a false test. We live longer. But by any other test it seems to me demonstrable that the average American human being grows poorer in stature, in resistance, in the use of his senses, and in the complete use of his bodily functions—including mental ones. For we have had no eugenics program, and the professions—social work, nursing and medicine—upon which the responsibility for eugenics primarily falls, have not yet made up their minds that they believe in it. They still look askance.

Consequently it is possible still in this country to have such happenings as these two. The first one came to my attention recently on a field trip I took in northern Florida, southern Alabama and Georgia, where I traveled for 800 miles in an automobile, visiting and talking to the so-called "poor white trash"—pitiful people. I talked to a mother who lived in a little one-room shack, characteristic of the whole region—no bed, no window, no stove. I asked her how many children she had given birth to and she began counting on her fingers, and finally she "reckoned" it was about twelve. There were eight scrambling at her feet—not a sound, decent one in the lot. They never can become good, sound human beings, and that woman is going right on breeding. She has never seen a doctor; she has never seen a nurse. The nearest doctor lives over seventy miles away but she has never seen him. She has never had any advice from anyone about the most important function she is performing, namely, family-building. She is replenishing the American stock. Nobody has ever helped her. Nobody has ever told her that it would be better if she spaced her children properly, not only in terms of her life but in terms of the future of these children. Nobody has ever told her about birth control, and so she goes on; and she can be multiplied by tens of thousands.

In the little rural county where I live in New Jersey (about fifty miles from the city of New York which boasts one of the best health programs in America), we made a study a few years ago of one of our degenerate families. There are 137 progeny of that family still living in the county, none of them any good. We made a budget to see how much it cost the taxpayers of the county to keep that family; and it cost us five times as much as the total budget for public health in the county every year, to keep one family of degenerate, diseased people.

You cannot rest comfortably as a professional person and think about yourself in relation to your country and its future unless you yourself ultimately adopt strenuous eugenics programs, which involve, in addition to family-building and family-planning programs, sex education and education for family life. We can no longer leave it to accident for young people to engage in marriage and in reproduction. Everybody must be trained for it, trained in the high school, at the moment when the tenderest feelings about family and affection grow. From there on there must be opportunities in every community for young people—and those who are no longer young—to learn about the most delicate, the most subtle, the most fateful function human beings ever perform, namely, to bring children into the world and to rear them.

EUTHENICS PROGRAM

But when we say "welfare," we mean also a euthenics program. For no matter how good the stock, if it cannot live in a good environment the consequences in the end will be bad. And so, when anybody challenges us to say what we mean by "welfare," we should state it in definite, simple, specific terms such as this: We mean that human beings in this country should live in decent houses. Over forty per cent of all the families of the United States are

now indecently housed. Why? Because we cannot afford good houses for people? That is nonsense. We could have had good houses for our citizens long before any other country in the world. And many small, poor countries have already furnished good houses for their people, long before we have made the first attempt, namely, to orient our laws, towards this end. Take a little, poor country like Denmark for example, or Sweden, where there are practically no natural resources; where there is no big endowment or invested money; where there are no millionaires. Nobody lives in a miserable house. Nobody lives in the kind of shacks I saw on the way across this continent last week on the outskirts of every city and town. Because forty years ago they started building good homes for people! We have not even started yet.

Also, when we say "welfare," we mean that people should have the finest medical care available. The diseases of our time are of two general types: those which are inherent, that is, come about by reason of organic defects; and those which are mechanical, that is, enter the body by means of microörganisms. In both cases we need programs of health. We need sanitation and medical control which will prevent the mechanical diseases—for they will attack good tissue as well as poor tissue. But we need also a medical program which will teach us how to live in a world surrounded by the multiplicity of stimuli which the technical world calls for and for which our organism is not equipped. Consequently, as you have been told in one of your convention sessions, all the diseases of the vital organism are increasing.

When we speak of human welfare, we mean, in the next place, economic security. We mean that the great hazards of life—sickness, death, unemployment, accidents—need not be borne by the individual alone. They may be shared. They may be made mutual. It is my opinion that no modern government can persist and be stable, unless it furnishes to its citizens this basic, economic security. Every country which fails to do it will be involved not only in unrest but in ultimate revolution.

These are simple terms, are they not? Everybody understands them. There is no lack of clarity about these three points of welfare. There is nothing Utopian about this. It is what everybody wants—or what everybody doesn't want, not for *other people*. For at the moment when the great American public—that is, those who make up the minds of the public, opinion-makers of American minds—decide that this is a decent goal, at that moment it will already have become practical and possible.

POSSIBLE IN TERMS OF HUMAN NATURE

For I assert there is nothing in human nature itself, there is nothing in the world outside of us, there is nothing in natural law or in economic law—and it is certain Providence has not decreed it—that people should live in diseased surroundings, surrounded by corruption and vice and crime. If there is any reason it is in us, because we have not yet made up our minds that it would be preferable to work for and to work in such a world than in one where a very small percentage of the population lives in luxury and great masses of people live in want and the fear of want. The moment we make up our minds that it will even be exceedingly adventurous to live in such a world, at that moment it will begin to happen. For, put in terms of human nature, it is safe to say—as it is of any other species in the animal world—our needs, wants, desires, and aspirations, are relatively small. Because we belong to the same species, we all want about the same thing. It is equally true to say in terms of human nature that our capacity to get what we want differs greatly. What, then, is the answer? Deprivation of those who lack capacity? Or is it not, rather, to merge all our capacities in such manner as to multiply our strength and consequently to bring to all the goods of a good life. Is it possible in terms of human nature? Yes.

When people say to you these days, "War threatens and is inevitable," and they sit back in a sort of fateful acquiescence, because "war is embedded in human nature," you must ask them

some searching questions. In whose human nature is war embedded? There have been long periods of history when men did not fight against each other. And warfare such as that now conducted among nations is utterly unknown to something more than two thirds of all primitive people still existing. The primitive people did not fight against each other as we do. Modern war is an invention of modern men. We are the killers, not primitive man, who is much more peaceful than we are.

No, man could live in a coöperative, collaborative world just as readily as he now seems to be forced to live in a competitive, struggling, fighting, scrambling, selfish world.

POSSIBLE IN TERMS OF WEALTH

And in the next place, when I ask the question, do we have the wealth for bringing such a good life to everybody, the answer is, potentially "yes"; actually "no, not yet." The average capital wealth of the United States in 1929 was a little less than $2500 per person. You can not have a good life on the income from $2500. Forty-two per cent of all the families in the United States have never had as much as $1500 a year family income. No, we have not produced enough wealth. But we can. The stuff is all there. The labor is there. The raw materials are there. The things are there, if we should start out tomorrow morning to build good houses for people, or even to bring good medical care to people. We now spend $6.00 per capita for medical care. What is the minimum estimate? The minimum would be $42, and good medical care in the United States as worked out by one planning group is $165 per person. Think how many more doctors and nurses we would need to have if we really brought health to America! We would probably have to double or treble our present professional growth—perhaps more than that.

Yes, it can be done. And now, finally, can it be done in terms of the American tradition—that is, within the framework of federalism, of the democratic principles—or must it be done ultimately by a dictator or a bureaucracy, or must it come about ultimately as a kind of gift, a paternalistic gift from the aristocracy? This is the great question. I speak to you now definitely as citizens. This is a great question. The fate of our country again hangs in the balance. A great crisis must now be met, as great a crisis as at any time in our past history.

In 1776 we had to decide whether we were to submit to the yoke of a tyrant or were to become a free people, launching out upon a great, audacious experiment, the most courageous and at that time called the rashest experiment in human history. And men's spirits were tried. There were some who sought to compromise with the tyrant. They did not become builders of this country. They are not now upon the lists of our heroes. We thereupon made the great experiment. For ten years following the Revolution there was anarchy, unrest, uncertainty. Finally a Constitution was adopted, and then the experiment actually began. But it only lasted a few years and again a great crisis arose. Could this Constitution hold this people together? Could we actually merge thirteen separate nations into one nation under the Constitution as adopted in 1787? And four years after the adoption of the Constitution it became clear that we could not do it, that the country must break up unless we quickly amended that Constitution to include—what? A basic charter of human freedom, the first ten amendments, which came all at once. The Bill of Rights, the finest assurance any governed people in the world have ever had: that under this government there was to be no tyrant; that human rights were to be preserved and human freedom assured. And then the experiment plunged ahead, and with almost unprecedented—if not unprecedented—success in the whole annals of human experience, we built a great nation. It is a peculiar story. Some day it will be told in peculiar terms.

And then another crisis came. This time the crisis had to do with whether this nation could hold together and maintain two directly opposing systems of economy. And again there were

thousands who wished to compromise with slavery, but happily the country as a whole did not compromise. It did not stay where it was, but it determined to move forward into a new era of freedom; and so it did, but after a very bitter, cruel civil war, an unnecessary war.

THE GOOD LIFE

And now you and I are being asked once more whether our generation will move forward under the ægis of this dream I related to you—the dream of a good life for all the people; welfare, the general welfare, not haphazard but planned for step by step, everlastingly striven for. Can this be achieved? And I repeat my former warning: if not, then we have met our greatest of all these crises. If we cannot solve this problem, then what is our fate? Another period of so-called prosperity reaching only a few and then an inevitable collapse, which next time will go deeper, be more sudden, more fateful, until the system has a whole collapse and ends in chaos. What are you to say when called upon in one of the great periods of our history to decide whether you want to go ahead or whether you want to compromise with poverty, crime and disease? Or do you wish to help build, to help plan a nation, in which every small local community plans in relation to its own problems—fixing those problems in the next area of relatedness, in the county, in the region, in the state, ultimately in the nation.

If we are a people equipped to feel and then to act in relation to such a plan, then I say we will have it and we will be the builders of a very great nation. And we may be, as the original founders of our country believed we might, the forerunners of a peaceful world, a world in which men no longer slug each other, a world in which our major preoccupation is not with things, with problems that ought to be solved; but a world in which our major preoccupation will be with flowers, with art, with the creation of beauty. I believe that is possible. I believe it will call for a greater and higher patriotism than any generations of Americans have ever been called upon to have before this time, but I have faith in it. I love this country. I suppose I love it in a way in which only the sons of immigrants come to love it, knowing that their fathers chose it out of all the world as the place to come and rear a family. I love it in the sense in which patriotism seems to affect us. I love the land; that is what patriotism is. The reason we have so many fake patriots and professional patriots in America is that we have lost the sense of loving the land and making it beautiful.

In finishing I should like to quote the words of my favorite Old Testament philosopher, the great liberal of the Old Testament, Isaiah. The first part of what he says is indeed familiar to all of you, but the second part perhaps is not. I quote Isaiah particularly because of his wisdom in relation to human motives and incentives and also because of his great social creed. You remember Isaiah said:

"How beautiful upon the mountains are the feet of him that bringeth good tidings. . . . For, behold, I create a new heaven and a new earth; and the former shall not be remembered, nor come unto mind. . . . And they shall beat their swords into plowshares, and their spears into pruninghooks: nation shall not lift up sword against nation, neither shall they learn war any more."

But Isaiah knew this would not come about by wishing. He knew this meant hard work; he knew what it meant in terms of economic power, and so he said:

"They shall build houses, and inhabit them; and they shall plant vineyards and eat the fruit of them. They shall not build and another inhabit: they shall not plant and another eat. . . . They shall not labor in vain, nor bring forth calamity."

To labor and bring forth calamity—that is not the destiny of men. Isaiah knew it. You know it, and therefore I challenge you in terms of the deeper feelings. In your heart you know that we can have the good life in this country. You know also that we have the intelligence and the technique and the material resources. Now I bid you, go forth and create the will.

The Family in Society

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AMONG animals, there are two types of association—the family and the herd. Both of these are of enormous antiquity and both of them have apparently arisen independently in different species on many different occasions during the long period of evolution. Since both have survived for so many millions of years, doubtless both have certain advantages.

Herd organization is found at its highest in the social Hymenoptera, particularly the bees and ants. It is also well developed among some mammals such as horses, cattle, and sheep. But the ancestors of mankind committed themselves long ago to family life as a primary group, rather than herd life. So far as one can guess intelligently, there has been surprisingly little change in the basic pattern of human family life in the last half million years. It is now too late to return to herd life, even if there were any good reason for doing so.

Of the historic peoples, Sparta perhaps made the closest approach to herd life, with results that represent a complete failure. In modern times, the Soviet Union has gone farther than any other civilized nation in trying to subordinate family organization and authority to herd organization and authority. Here again, the results have been unsatisfactory, and the Soviet rulers, unlike the Spartans, have been intelligent enough to recognize their mistake so that in recent years there has been a steadily increasing tendency to promote family organization as compared with the opposite tendency that was so marked immediately after the revolution of October, 1917.

A survey of the past shows—and I believe there are no exceptions to this—that in the history of any nation the highest stage of civilization has coincided with the strongest family life. As one deteriorates, the other also decays. I think it may be assumed, without further argument, that family life represents an adaptation of the highest value in promoting human evolution; and that a sound and permanent civilization can be built only on a sound family life.

Sound families must be made up of sound people, healthy and vigorous not only physically but likewise in intellect and emotions. Unless culture favors such families, it cannot survive.

HEALTH PROTECTION OF FAMILY

Our own culture is falling short in many ways. While tremendous sums are spent to prevent or cure many physical diseases, the group that is perhaps most serious to family life, namely, the venereal diseases, has been largely neglected. Scientifically, we have all the necessary information to control, even to eradicate, syphilis and gonorrhea. It is our own inertia and indifference that prevent us from putting these at least in the same position now occupied by yellow fever and typhoid fever. We can have no pride in the scope of our public health measures, we cannot even pretend to be civilized, so long as we maintain our present attitude toward the venereal diseases.

The family is equally threatened by mental diseases, and here again we are ignorant and niggardly in our measures. Patients with mental disease occupy more hospital beds than do all other patients put together, including not merely the sufferers from all the ills that flesh is heir to, but all the victims of automobile and industrial accidents, all the women in childbirth, and all other persons who go to a hospital for any reason whatever. While a relatively great organization and budget are avail-

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able to deal with physical diseases (even though our effort is far less than it should be) the inadequacy of our effort to prevent mental disease is a grim absurdity. Dementia praecox alone, which fills more hospital beds than any other one disease, physical or mental, costs the United States at least a million dollars a day. Would it not be good economy to match each of these dollars of loss with one cent expended for research and prevention?

PREVENTION OF DISEASE

If family life is worth preserving, it must be preserved so far as possible from disintegration by disease, whether it be a physical disease such as syphilis, or mental disease such as dementia praecox. I say nothing about mental deficiency, but it is obvious that family life cannot be carried on successfully by imbeciles, though the records of every county will show instances where such an attempt is made for generation after generation. "Three generations of imbeciles are enough," remarked Oliver Wendell Holmes in handing down the Supreme Court decision upholding the constitutionality of the Virginia sterilization law. Few would disagree with his conclusion.

Family life, which is to serve as a foundation for society, must then be protected from disease—whether mental or physical—and it must produce children of a quality such as to make possible a continuance of our civilization. It must at least produce enough sound children to take the places of the parents when they die; otherwise the nation will gradually disappear. The American population, however, now contains fewer little children than it did fifteen years ago.

Here in California we have no cause for pride since the birth rate of the native whites is the lowest of any state in the Union. The 1930 census showed that only 69 per cent enough children are being born in this state to keep the population even stationary. This is not, as many have supposed, because California is largely settled by elderly people, the birth of whose children is credited to some other state in earlier years. A glance at the census returns shows that California has more than its quota of women of child-bearing age, whether that age be taken as from twenty to thirty-five or from fifteen to forty-five. The marriage rate in California is high, but the marriages produce few children. A sound family life cannot be built up on sterile marriages.

Not merely in quantity, but also in quality, is the family often failing to justify itself. The two-child family is virtually standardized among college graduates of the United States. But it is not standardized among the feebleminded or among the chronic paupers. Here a four- or five-child family is more nearly the rule. Several years ago I studied families that had been dependent on the Los Angeles County Charities since at least 1927, when prosperity was thought to be widespread. These long-time dependents averaged not two children but five in a completed family, and a third of these children had been born after the family became dependent on charity. Obviously the more children they have "on the county," the more difficult it is for them to become self-supporting; and in the older states every social worker knows that some of these dependent and feebleminded families are "on the county" not merely from year to year but from generation to generation.

What can be done to improve the inherent quality of families in the United States? Two lines of action at once suggest themselves. On the one hand, measures may be found to reduce the number of inferior and defective children born. On the other hand, measures may be found to increase the number of superior children born. America must act along both lines if it is to safeguard family life in the future.

PROGRAM TO REDUCE INFERIOR POPULATION

The negative program which proposes to reduce the number of inferior children born is fairly simple. Several measures are available which are not experiments but which have been found effective by long use and which are humanitarian and desirable.

1. Abolition of child labor is an illustration. It seems hard to believe that any parent will produce children for revenue only, but it is a fact that abolition of child labor has been followed by a decrease in the birth rate of that part of the population which formerly contributed the child labor. Since child labor should be abolished for every reason, a more vigorous drive in this direction will also tend to reduce the number of large but inferior families in the population.

2. Raising the minimum age of marriage is another measure which is desirable for every reason, and will also help to reduce the handicap of intelligent and educated parents. At present there are a dozen states which still allow a boy to marry at fourteen and a girl at twelve. Another glance at the 1930 census shows that 824 boys of fourteen were enumerated as married, widowed, or divorced. The number of girls of fourteen and less, in the same category, was 4,506. Presumably all these boys had married within the census year. If the average duration of marriage be taken as twenty-five years, then 824 could be multiplied by twenty-five to give an idea of the number of married men in the United States who entered into matrimony at the age of fourteen. It would appear that there must be at least 20,000 of them in the country, while the number of girls who married at fourteen or less must be well over a hundred thousand; and if one takes the girls who married at sixteen or less, the total is undoubtedly well over half a million.

Marriage is an enterprise for adults, not for children. Apart from all the other valid grounds for discouraging child-marriages it is evident that they have too great a head-start in producing offspring. The girl who marries at sixteen has a ten-year advantage over the college girl. She has probably produced three, four, or five children before the college girl is even betrothed. If these children were superior in quality the situation would be a little less serious. But it is hard to believe that the families which let their girls marry at fourteen or fifteen come of the soundest, most intelligent, and most stable stock in the country. Child-marriage should be abolished along with child-labor.

3. Again, marriage can be protected by reasonable state regulations. About one fourth of the states now require a physical examination of the male before marriage. The main intent of this is to prevent men from marrying while in an infectious condition with a venereal disease. This is a desirable purpose, though the law should probably be applied to both sexes. But mental disease may threaten the marriage just as much as physical disease. Finally, mere ignorance may be just as disastrous as either one. It is hard to see how a satisfactory law covering all this ground could now be passed by state legislators or administered if passed, but in the meanwhile, public opinion can at least be educated to demand a thorough examination and real preparation for marriage as an unwritten law.

In addition, nearly one half of the states have now returned to the church's old custom of publishing the banns, by requiring a short advance notice before a marriage license is issued. Even a three-day delay leads to the abandonment of many marriages that otherwise would be contracted. In Los Angeles County alone, in one year, 1200 couples went to the courthouse together, declared their intention to marry, signed the necessary applications, and then did not return to get their license. It is difficult to believe that any marriage which is not viable for three days in advance would stand the stress and strain of twenty-five years afterward! There is no question but that such a law prevents many freak marriages, fraudulent marriages, drunken marriages, runaway marriages, marriages in which the girl is under age, and other matings that would end only in disaster individually and socially. Laws of this sort should be adopted by every state. It is hard to imagine any measure of the sort which can do more good and yet can injure no legitimate interest.

4. Spread of contraceptive information to families in the lower social, eco-

nomic, and educational levels of the population is increasingly accepted as desirable. The Los Angeles County Department of Health maintains thirteen Mothers' Clinics for this purpose at the expense of the taxpayers, and the health department of the city of Pasadena supports one on its own account. The mere maintenance of clinics, however, is far from enough to meet the needs of the part of the population mentioned. In many instances proper instruction should be taken directly into the home.

Unless a vigorous educational campaign of this sort is carried on, no one can expect to see adequate results in preventing the birth of too many children in homes where they will be certain to have the worst possible start both in heredity and in surroundings.

5. Even an aggressive campaign of this kind, however, would not be sufficient since some families are so feebleminded, so indifferent, so alcoholic, so irresponsible, or so willing to produce children for the sake of an increase in their dole, that no voluntary measures will succeed. To meet this type of problem, California, along with twenty-seven other states, now provides sterilization. In most of the states, including California, the law is applied only to those who are legally committed as insane or feebleminded to state institutions. During the past twenty-six years, California institutions have sterilized about 11,000 patients in this way. But it is obvious that many low-grade families would welcome sterilization as soon as they understood that the operation does not unsex the patient or change his life in any other way than to prevent parenthood. Most of the protection needed for this purpose could certainly be given voluntarily and every county hospital should be open to legitimate voluntary patients seeking sterilization for adequate reasons.

Sterilization is no panacea, but it now has thirty-seven years of experience back of it in the United States and it is certainly not a novelty or an experiment. More than 160,000,000 civilized people now live under eugenic sterilization laws and it seems certain that much more widespread use of this operation in voluntary cases will be made during the coming years.

The measures I have been describing can be depended upon, if properly used, to reduce the present excessive birth rate in parts of the population that are not only unable to produce leadership, but rarely able to produce even healthy and normal children.

On the other side, however, it is equally important to strengthen family life in America by encouraging the birth of children in families where they can be given the best hereditary endowment and the best opportunities for growing up successfully. This is largely a question of social attitudes. Apart from general education measures, there are several special problems that deserve more attention.

EDUCATED WOMEN FAIL TO MARRY

One of these is the low marriage rate of educated women. Nurses offer a good illustration of this almost universal tendency. It appears that little more than one half of the graduates of the average school of nursing ever marry. Yet they represent a highly selected group in physique, in intelligence, and in emotional normality, not to mention the fact that they have an education which fits them for motherhood much better than does the education of most women. Socially and eugenically, there is no excuse for such a situation.

Failure of nearly one half of all graduate nurses to marry cannot be ascribed to their own inherent inferiority. It must be due, then, either to their attitudes, or to their lack of opportunity. If they have been so educated that they do not want to marry, then their education is antisocial. If they want to marry, but fail for lack of opportunities, then the profession itself should take energetic measures to change those things that are in its own control, such as the social life of students, and to coöperate in changes that will affect all educated young people in the direction of making marriage in the early twenties possible.

Perhaps more aid to young people in

making a wide range of acquaintances at the proper time would do as much as any other one thing to encourage marriage. Beyond this, society can and must still offer some definite help in education for marriage and in meeting the problems of family support.

On the whole, it appears that economic pressure is as much responsible as any other one thing for the small families of educated people. A very serious situation has arisen through a misinterpretation of the slogan "equal pay for equal work." This is universally taken to mean that a salary is attached to a given job and anyone who gets the job gets that salary. How does this equality work out in practice? In order not to be too invidious, let me take an imaginary illustration from the teaching rather than from the nursing profession.

Here is a high school which pays its principal $3000 a year. Anyone who gets the job, whether male or female, married or single, gets $3000 a year. That is "equal pay for equal work." If a bachelor is appointed, he has $3000 a year on which to live. If a married man, with a wife and four children, is appointed, he does not have a chance to live on $3000 a year because from this sum he must deduct the cost of supporting his wife and children. Economists figure that each minor child absorbs about 15 per cent of the father's salary. Suppose that four times 15 per cent, or 60 per cent of the salary be allowed for the four children, and 20 per cent for the wife. Then the principal must set aside 80 per cent of his salary for his family, leaving him 20 per cent or actually $600 a year for the same job which pays the bachelor $3000. Obviously this is not equal pay for equal work, but a ghastly joke.

Now, suppose the principal and his wife decide to have another baby. Then, in effect, they suffer a 15 per cent cut in salary because they will have 15 per cent less for the rest of the family than they did before the baby was born. A 15 per cent pay cut is heavy punishment even in these days of reductions, and it is not surprising that they hesitate before accepting a reduction of this sort in their standard of living.

Suppose, on the other hand, that they talk the matter over and decide not to have the baby. Then, in effect, the Board of Education will give them a bonus of 15 per cent, because they will have 15 per cent more for the family next year than they would have had if they had gone ahead with their plans for another baby! With this inexorable and savage system of punishment for having children and rewards for going without them, it is not surprising that the white-collar class tends to standardize its children at two per marriage—which means that the number of families smaller than that is just as great as the number of larger ones.

Is it not evident that the idea of "equal pay for equal work" has been seriously misapplied? Everyone has been deluded because he has looked only at the face value of the pay check. It is not that, but the standard of living, which actually counts; and the only sort of equal pay for equal work that is tolerable is an equal standard of living for equal work.

THE FAMILY WAGE

This can be provided through the principle of the family wage, which is again a well-tried one. It proposes to establish a basal wage for any job and to pay that basal wage to anyone, male or female, married or single, who gets the job. In addition, there is an allowance for each minor child and for a dependent wife or husband.

To follow out the hypothetical illustration, suppose that a high school pays its principal a basal wage of $2000. The bachelor, or the unmarried woman, will get that salary. If the position is awarded to a man with a wife and four children, he will get the same salary but an additional allowance of say 15 per cent for each child and 20 per cent for his wife. He is, then, actually getting $3600 a year for the job which pays the bachelor $2000, but since the additional allowance is offset by the maintenance of his family he does not have a cent more to spend than the

bachelor. On the other hand, he does not have a cent less and he can maintain the same standard of living as the bachelor does without having to sacrifice the health or education of his children.

With such a system, there would be no financial inducement to have children. If the principal and his wife had a dozen, they would be no better off than if they had one. They could not make a cent by parenthood. But neither could they lose. If they wanted to indulge a eugenic propensity, they would not be punished for it by having to reduce the family's standard of living and to sacrifice the future of the children they already had.

To prevent discrimination against family men and women, and the hiring of the unmarried as "cheap labor," the equalization pool is an essential part of the machinery of administration. This can best be understood by following the hypothetical teacher one step farther.

Suppose there are one hundred high schools in California, each of which is justified in paying approximately the same salary to its principal. These are formed into an equalization pool, with the basal salary of the principal fixed at say $2000. The trustees select the most competent candidate for the position, without regard to sex or family status, and pay that basal salary. In addition, they pay family allowance on the terms already described, so that one principal may receive $2000, another $3600 or more.

These salaries are not paid directly by the local board but a central office, probably at the state capitol, and this office then collects from the local board not the amount that its principal received, but one one-hundredth of the total payroll of that pool. Thus every local board of education is paying exactly the same for a principal, but the principals themselves are getting different amounts depending on their family obligations. (In at least one American college which has applied the family wage to its faculty, a dependent parent is counted the same as a dependent child.) Each board, for instance, may be paying $2900 a year for its principal, while the principal himself may be getting anywhere from $2000 to $4000 or more. The local board gains nothing by hiring a bachelor, and will have no reason to do so unless he is the best qualified candidate who presents himself.

PLAN ALREADY TRIED

The principle of the family wage is not new. John Wesley started his Methodist ministers out under it nearly two centuries ago. Protestant foreign missionaries have long benefited from it. In France it has been used for half a century, and a large part of the laboring classes of that nation, and others in Europe, are now living under it.

It could be applied most easily to such groups as the civil service employees, army and navy officers, educators, clergymen, and public servants. Its widespread use in the white-collar classes would represent, in a sense, a redistribution of wealth, based on social need and social contribution. But it would have the advantage over some other plans for the redistribution of wealth, that it need not cost the taxpayers a cent more than they are now paying for the same services. The same amount of money would be distributed; but it would be alloted in a way that would, far more than the present system, be eugenically desirable, economically fair, and socially just.

Along with wider recognition of the importance of the family in society, and of the necessity for more vigorous support of family life, America can easily apply on a large scale such measures, negative and positive, as I have here briefly outlined. The future of the United States depends on an understanding of this situation, and on action to correspond. Unless a nation produces enough children to take the places of people who die, it will steadily decline in quantity. Unless it produces those children from the fit, rather than from the unfit, part of the population, it will decline steadily in quality. *Decline and fall—or survive and prosper.* The direction followed will depend on how fully a nation supports its family life.

Health Situations in the Family *

By ESTELLA FORD WARNER
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THE use of mortality statistics as an instrument for determining health needs within a given area is familiar to each of us. We also know how hopefully we watch for declines in mortality rates as a measurement of possible achievement. The reasons for the widespread usage of such data are obvious. They afford the most reliable information we have for death by locality, age, sex, specific diseases, and occupation, together with time trends. But mortality statistics, useful as they are, tell us only of those conditions that are associated with death. They do not present a true picture of health situations within a family or community. They disclose nothing concerning the sickness picture which is one that is very much different from that determined by mortality. There is no mass of data on the health status or even illness incidence comparable to that on mortality. The best we can do is to turn to some few studies that have been made recently to find an indication of what some of the health problems are in a small group—namely, the family.

There have been studies made of the incidence of illness on a given day among large population groups. These findings are helpful, but they do not give a clear understanding of health problems. They indicate the prevalence of sickness at a specified time but the data are heavily weighted with chronic illnesses, which is quite different from findings obtained from observation of groups over a long period of time in which all illness is recorded, including that of an acute nature which exists but for a few days. One source of information which is illuminating is a recent study of 9000 families** covering the period of one year wherein regular visits were made to these families and all illnesses recorded.

The first striking observation is that the major causes of death in this group were not the major causes of illness. Circulatory diseases accounted for twenty-one per cent of all deaths but contributed to only three per cent of the illnesses. On the other hand, forty per cent of all illnesses were due to respiratory diseases, including tuberculosis, while but sixteen per cent of the deaths were attributable to these causes.

Another interesting observation concerns the incidence and cause of illnesses which are disabling, those which are non-disabling, and of conditions attended by no illness but requiring professional care. The term "disabling illness" signifies those sicknesses which necessitated one or more days in bed or away from usual activities. It is interesting to note that respiratory diseases rank first among both the disabling and non-disabling illnesses in families; communicable diseases are second among disabling sicknesses and sixth in the non-disabling group; digestive disorders appear third in both groups; accidents fourth in the disabling and second in the non-disabling classification.

A further point of interest relates to illnesses requiring hospital or surgical care. Three fourths of all hospitalized or surgical cases are attributable to four causes: (1) respiratory conditions, including tonsil and adenoid operations; (2) puerperal and gynecological conditions; (3) digestive disorders, including appendicitis; and (4) accidents.

Persons who were not ill but sought professional care obtained services largely of a preventive nature. Dental

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**"A General View of the Causes of Illness and Death at Specific Ages." Public Health Reports, February 22, 1935. U. S. Government Printing Office, Washington, D. C.

care constituted sixty-one per cent of the cases, physical examinations seventeen per cent, immunization eleven per cent and eye refractions ten per cent.

AGE GROUPS WHERE ILLNESS OCCURS

At what age levels do these illnesses and deaths occur? Respiratory conditions leading as a cause of illness for all age-groups contribute two fifths of all sicknesses among preschool children and children of school age and about a third among persons past seventy-five years of age. A fact which needs serious consideration is that respiratory illnesses, representing largely pneumonias and tuberculosis, cause one third of all deaths among young adults (ages 15-25 years) and lead all other causes of death in this age group. The degenerative diseases—circulatory and kidney ailments, and nervous disorders—produce a third of all illnesses and three fourths of all deaths in the oldest age group, while under five years of age they account for about four per cent of the illness and eight per cent of the deaths. Accidents are an equal cause of disabling illness among all age groups, but as a cause of death reach the highest peak among children and young adults.

It was found that the illness rate in this study was approximately one case per person. That does not mean that every person was sick once during the year's time. Actually, almost one half were not sick at all during the year, one third were sick once, and about seven per cent were ill three or more times. The age group reporting the most frequent illness was that of children under five years. Thirteen per cent of these children were sick three or more times compared to four per cent among the group between fifteen and nineteen years of age. The high occurrence of illness among children under five years reflects the incidence of communicable diseases, of which measles and whooping cough take the lead.

Because these findings are revealed in a study of 9000 families representing approximately 40,000 persons is no indication that they would remain constant among the total population. However, the numbers are sufficiently large to warrant consideration and provoke serious thought as to whether in our public health work, we are giving sufficient attention to some of the real health situations the family faces. It is not to be supposed, either, that the conditions thus far cited represent *all* the health problems a family must meet. We have on many previous occasions discussed maternal health, infant and child health, communicable diseases, tuberculosis, and environmental sanitation, and have included measures meeting these problems in public health programs. State and local public health agencies are now experiencing, through facilities made available by recent federal legislation and appropriations, an opportunity to expand their programs to meet more nearly the changing concept of public health function and to fulfill better the health needs of the families and communities they serve. This very opportunity for constructive work carries with it the responsibility of realistically surveying our public health activities and scrutinizing their usefulness and productivity.

ARE WE MEETING THE PROBLEMS?

How far have we gone in meeting the problems in relation to respiratory diseases, especially pneumonias and tuberculosis among adolescents? We know that tuberculosis leads all causes of death in this age group and presents a real public health problem. What consideration have we as public health workers given to the prevention of accidents? In 1930 in the United States there were twice as many deaths from accidents among children under fifteen years of age as there were deaths from diphtheria, measles, and scarlet fever combined. Burns took highest toll in accidental deaths among the one- and two-year olds, mechanical suffocation among those under one year, and in the 5-9 and 10-14 year groups automobile accidents led.*

*Gafafer, William H. "Mortality from Automobile Accidents Among Children in Different Geographic Regions of the United States, 1930." Public Health Reports (In Press). U. S. Government Printing Office, Washington, D. C.

Furthermore, have we given recognition in our maternal health programs to the fact that about one fourth of all puerperal deaths follow abortion; that about one third of all puerperal deaths occur before the last trimester with septicemia associated with abortions as a chief cause; that the largest factor in miscarriages in the last trimester is syphilis? Have we faced the problem of syphilis as a communicable disease seriously affecting the health of the family? How seriously have we considered the social aspects of housing, employment, economic security in old age, medical care, and community facilities for medical service as related to the whole field of public health? The health of the individual as a part of a social unit—the family—is our objective. Our responsibility includes an analysis of our present practices in the light of knowledge within our possession, and an effort to translate that knowledge into new and effective procedures.

The present-day opportunity for constructive service which confronts each person engaged in the field of public health is a challenge to lift his vision beyond the habit of the past, the routine of the day, up to new aspects of health situations facing the family so that public health may be "an arch where through gleams an untravelled world" of health and happiness for all our people.

WHERE TO FIND OTHER CONVENTION PAPERS

The *American Journal of Nursing* published in its July number:

"The American Nurses Association 1934-36"—Susan C. Francis
"Looking Toward Tomorrow"—Aurelia Henry Reinhardt, Ph.D.

while in the August issue of the *Journal* appeared the following:

"The Private Duty Nurse in a New Era"—Susan C. Francis
"The President's Address" (N.L.N.E.)—Effie J. Taylor
(Good summary of League activities)
"Promoting Professional Growth of the Faculty"—William A. Burton, Ph.D.
"The Preparation of Teachers for Schools of Nursing"—Edna Bailey, Ph.D.

and a general report of the Convention, giving the high lights of the program of both the American Nurses' Association and the National League of Nursing Education.

In September the *Journal* plans to publish Miss Stewart's report of the Curriculum Committee.

To appear in early issues of PUBLIC HEALTH NURSING:

"Relationship of Public and Private Agencies"—Ernestine Schwab
"Applying What We Know in Mental Hygiene"—Bertha C. Reynolds
"Health Teaching in the Small Industry"—Lucy DeMuth
"Tuberculosis Nursing Is Mental Nursing"—Leah M. Blaisdell
Report of the Joint Committee on Community Nursing Service—Lulu St. Clair.

Topics from the N.O.P.H.N. Round Tables planned for early publication in the magazine are as follows:

"Continuous Professional Growth—The Contribution of Postgraduate and Staff Education"—Ruth Hay
"Nursing Education as a Selector of Public Health Nursing Candidates"—Henrietta M. Adams
"The Public Health Nurse in the Control of Congenital Syphilis"—Emily F. Bolcom, M.D.
"Strengthening State and National Relationships"—Elsbeth H. Vaughan
"Seeking Tuberculosis in Its Haunts"—Fannie Eshleman
"Heart Disease as a Public Health Problem"
"Public Education for Prevention"—John Sampson, M.D.
"How the Public Health Nurse Can Coöperate"—Alma Gravem
"The Educational Value of Records"—Marian G. Randall.

Miss Tittman's paper, "National Vocational and Placement Service in Public Health Nursing," which was presented at a general session of the American Nurses' Association, will be published later, as will also further papers from N.O.P.H.N. Round Tables.

The American Nurses' Association will publish complete Proceedings, which will include all papers given at A.N.A. and Joint Sessions. The National League of Nursing Education will also publish its complete Proceedings.

California Nurses Star at N.O.P.H.N. Luncheon

A UNIQUE and delightful entertainment was provided by the California nurses for the guests who attended the N.O.P.H.N. Membership Rally Luncheon on June 25 at the Biennial Convention in Los Angeles. An original two-act skit written by Lillian Simpson and presented by a cast of Los Angeles nurses, met with enthusiastic response, and we are happy to comply with the numerous requests that it be published.

Between acts of the playlet, a sextette in Spanish costumes entertained the audience with music. During the singing of the *Song of Welcome* (reproduced on page 581) the singers assembled before the speakers' table and presented an enormous key to the city to Sophie C. Nelson, Luncheon Chairman. Miss Nelson accepted and expressed warm appreciation on behalf of herself and the guests.

Miss Nelson announced at the luncheon that the N.O.P.H.N. goal is 10,000 members of the next Biennial.

The Quintuplets Become Nurses

By LILLIAN SIMPSON, R.N.*

CAST OF CHARACTERS

The cast was composed of Los Angeles nurses from the following organizations: Bureau of Public Health Nursing, Department of Health, County of Los Angeles (5); Board of Education, City of Los Angeles (1); Metropolitan Life Insurance Company (1); General Hospital, Los Angeles (1).

Charmian A. Ehlers acted as NARRATOR and the part of the NURSE appearing in the second act was taken by Alicelee Byers. The other members of the cast are pictured below: DR. LADIEUX: Lillian Simpson. (Left to right) QUINTUPLETS—MARIE: Adah Kirkpatrick; YVONNE: Bernice McKinney; ANNETTE: Euna Turpen; CECILE: Martha Zweibel; EMELIE: Esther Colvin.

*Director, Bureau of Public Health Nursing, Department of Health, County of Los Angeles, Los Angeles, California.

INTRODUCTION

NARRATOR: We are presenting here the Dionne Quintuplets, whom we are following in imagination to their grown-up state at the age of seventeen. You are familiar with their history, how they were born in the little town of Callander, Canada, in a poverty stricken home, attended by a country doctor; how the world was startled and thrilled to learn that they all survived, the first in medical history; and how the people responded to the great need for adequate supplies for their care. You also know that the Canadian Government erected a modern hospital to insure them scientific care. We have presumed that from their association with the devoted Dr. Dafoe and the kind and efficient nurses, they decide upon the profession of nursing as a vocation.

We now present Emelie, Cecile, Yvonne, Marie and Annette, at the age of seventeen years. Having recently spent four years in the Montreal High School, they visit their old friend, Dr. Dafoe, seeking his counsel in selecting a school of nursing.

CURTAIN

ACT I

TIME: Spring, 1951.
PLACE: Dr. LaDieux's living room.
Introducing Dr. LaDieux, representing Dr. Dafoe.

SCENE I

Enter Dr. LaDieux—bent and white haired, reclines on couch reading Montreal paper, awaiting a visit by the Quintuplets.

Enter the Quintuplets—five dark-haired, brown-eyed girls, dressed in white linen suits. They rush up to the doctor, greeting him enthusiastically. He responds, calling each by name. The girls laugh at him merrily.

DR. LADIEUX: What is now so funny?

MARIE: You made one mistake, papa. I am Marie and you called me Emelie.

DR. LADIEUX: So? Well, what is one small mistake? After all four years is a long time and you have grown so! And you were always the smallest one.

EMELIE: I'm not surprised, our teachers were always getting us mixed up.

MARIE: Yes, except in examination papers—and you always got higher marks than I did.

DR. LADIEUX: Tut-tut, no quarrelling, you two. You were always at it.

ANNETTE: We came particularly to see you, papa, because we need your advice.

DR. LADIEUX: So?

CECILE: All through high school we have talked about you and missed you and the nurses so much. We have all decided to become nurses.

DR. LADIEUX: It's a hard life, my dear.

ANNETTE: Not nowadays. We have sent for a catalogue. Everything has changed in the nursing schools and nurses have it easy now.

DR. LADIEUX: Easy? Well, I hope so.

YVONNE: And we have always wanted to go to the United States. You look at the catalogue and tell us what you think.

DR. LADIEUX: Well, I retired so long ago—but I shall try. (*Adjusts glasses; leans forward, scowling slightly, reading catalogue.*) (*Reads aloud*): "Nursing course at the Central University School of Nursing, including full college course of eight years." (*Registers surprise, looks up at the girls*): Eight years!

CECILE: Oh! won't it be wonderful!

(*All the girls register glee.*)

(*Doctor and girls look through catalogue.*)

DR. LADIEUX: In order to be nurses, you must take all this college work?
CECILE: Yes, those courses are included in the curriculum of Central University.
DR. LADIEUX: Ah, this is interesting! Medical and surgical nursing, obstetrics, pediatrics, edocrinology, and child psychology.
YVONNE: I've always wanted to learn how to manage children.
ANNETTE: And look at the sciences we have to take!
DR. LADIEUX: That's more than I had in medical college.
EMELIE: Yes, in economics we learn budgeting; all about state benefits and pensions, and there's even a course in family case work.
CECILE (*pointing*): And there are courses in sanitation, hygiene, epidemiology and vital statistics.
DR. LADIEUX: Ah, those are very fine! Think of the struggles I had with epidemics before you were born.
MARIE: And public speaking and radio broadcasting.
ANNETTE: Oh, yes, and journalism.
DR. LADIEUX: Ha! ha! And here's a course in problem parents! That's an epidemic difficult to control.
ANNETTE (*turning the page*): Here's a course in family relations, see? It includes personal charm, courtship, a peace program for mothers-in-law and mental hygiene. All these will help to prevent the growth and development of problem parents.
DR. LADIEUX: Well, this training carries out my ideals for you which I could not realize myself. (*Turns pages.*) I see many interesting courses for you.
EMELIE: And I can go on with my voice culture.
CECILE: Aesthetic dancing appeals to me!
MARIE: I want to go on with my short-story writing.
ANNETTE: Then you approve of our plans, papa?
DR. LADIEUX: Yes, my dears, only I shall have to consult your Education Committee. This will make you very useful and happy women. *But*—you are not *all* going?
THE QUINTS: Yes, yes! (*with enthusiasm.*)
MARIE: And oh, papa, think of the degrees we shall have when we graduate! R.N.—A.B.—B.S.—P.H.N.—M.A.—Ph.D. and P.P.
DR. LADIEUX: P.P.—What is that?
MARIE: Perfect parent. The Government requires everyone to have that before a marriage license is issued.
DR. LADIEUX: Well, well! How things have changed. My advice to you is—*go!*
GIRLS: Oh, goody, goody!
DR. LADIEUX: But you will be so *far* from *me.*
ANNETTE: Oh, we shall write you! We just couldn't forget you! Will *you* write to *us?*
DR. LADIEUX (*wiping his eyes with handkerchief*): Yes, my dears. I hope I shall be here when you return, *oh,* so full of wisdom.
CECILE (*looking at wrist watch*): Oh, we must go!
YVONNE: I wish we had not made that engagement at 5:00 o'clock.
DR. LADIEUX: *Must* you go? Where is your car? I shall accompany you.
Exit Dr. LaDieux, the Quintuplets assisting him.

CURTAIN

NARRATOR: The Quintuplets took the doctor's advice and entered the Central University School of Nursing. The number of entrants to the nursing course is restricted to a small group of exceptional young women, with intelligence and personal charm. The tuition is $1,000 per year, and upon completing the course, the graduates are in demand all over the country for every type of

service. The young women look much the same as they did when they said goodbye to Dr. LaDieux, because the hours of study were short, with no arduous work and plenty of time for rest, recreation and cultural subjects.

CURTAIN

ACT II

TIME: Fall of 1961.
PLACE: Dr. LaDieux's living room.

SCENE I

Enter Dr. LaDieux, in dressing gown and slippers, assisted by his nurse, who helps him to the couch, adjusts the cushions, covers his legs with a slumber robe and admonishes him to rest. Though very aged and feeble the doctor enthusiastically awaits the return of his "babies" from college. The nurse leaves him with a book.

Enter the Quintuplets, dressed in gay-colored futuristic dresses and hats of cellophane. They burst in upon the doctor, smothering him with hugs. The doctor sits up at their entry. He is very much overcome and exclaims:

DR. LADIEUX: Oh, la, la, don't skip around so much! Please sit down! (*Reclines on couch.*) (*The girls look at each other sadly, realizing all at once how very feeble their friend has grown*).

DR. LADIEUX (*looking fondly at the "Quints"*): It is so good to see my babies again! And I have missed you so!

ANNETTE: And we have missed *you, too*—oh, so much!

CECILE: Oh, it is so good to be in Canada again, and just now when the maple leaves are turning! It is so lovely.

DR. LADIEUX: Beautiful! Now, tell me what you have been doing. You all look so fresh and young, I do not believe you have been working at all!

YVONNE: Oh, yes, we studied *four hours every day* and have learned a great deal.

DR. LADIEUX: Tell me all the new things you learned about caring for patients.

EMELIE: Patients? We never saw them!

DR. LADIEUX: You never saw them!—but—I thought you went to a nursing school.

ANNETTE: Oh, we learned all about the care of patients, but the robots did all the work. *We studied.*

DR. LADIEUX: *Robots?* How can that be?

YVONNE: Oh, we read the doctor's orders and called the hospital by telephone and gave his instructions to the robots each day—they took all the bedside care of them.

CECILE: And for special treatments we pressed a button, and the patient would be electrically transported to the treatment room and put on a revolving platform.

MARIE: And as each case came before the robot-nurse, she followed radio instructions and gave the prescribed treatment; then pressed the button and the electric cart took the patient back to his room.

DR. LADIEUX: Mon Dieu! I can't grasp it! How do the doctors like these new methods?

CECILE: Very much. The robots never make any suggestions to the doctor or upset the patients by telling them what they think of the treatment.

EMELIE: Oh, papa, you would have loved the nursery! They have special robot diaper changers, and at feeding time they changed thirty-five babies in no time and put them in electrically operated baskets which shoot them overhead, directly into each mother's room.

DR. LADIEUX: The poor little things! How could they get out of the baskets?

YVONNE: It was very simple. The room-robot lifted them out gently, and put them to work.

DR. LADIEUX: This is a wonderful age we are living in—painless childbirth, robot-care! And how I went from house to house in the snow and no nurse to help me! Tell me, you took economics and nutrition; did you learn to serve nice trays to the patients?

ANNETTE: Oh, no! We just learned about food combinations and budgeting. All the patients' meals were served in capsules by prescription.

DR. LADIEUX (*smiling*): Well, I shall continue to take mine the old fashioned way. And here is another question: When you left me you said the course would be eight years, and it has stretched out to ten. What happened?

EMELIE: We became interested in public health nursing, but found we couldn't get a degree without taking two additional years at the Central University. The National Organization for Public Health Nursing in the United States has for *years* been raising educational requirements.

CECILE: Yes, we majored in public health and now we are qualified health educators.

YVONNE: You'd be surprised how health officers all over the country are constantly applying to the Central University for public health nurses.

DR. LADIEUX: I suppose you had also, robot-teachers, yes?

EMELIE: No, the N.O.P.H.N. in New York has a system whereby all instruction is given through leased wire by television. In that way you can see your instructor and get to know her very well. The inspectors from National Headquarters visit the nursing schools by aeroplane, weekly.

ANNETTE: Yes, and don't you see, the curriculum and instruction is standardized all over the country.

CECILE: Oh, papa, you'll be so glad to know that diphtheria in the United States has been *completely eliminated by universal immunization!*

DR. LADIEUX: Marvelous! How about tuberculosis?

EMELIE: There is very little. Almost all the old active cases have died. The others are isolated, and all their contacts have received such excellent care that no new cases have developed.

YVONNE: There is a law that all the school children and teachers must have a thorough physical examination each year and be tested for tuberculosis. All parents are x-rayed twice a year, so the control is almost 100 per cent.

DR. LADIEUX: How about home care of the sick?

MARIE: Bedside nursing has been established throughout the country for *everyone* —even those who can pay. For *years* there has been no difficulty in collecting fees. It's just like paying your electric light bill. *No* one objects. It is really a wonderful service!

DR. LADIEUX: It seems incredible! And now, what are you all going to do?

ANNETTE: I'm to be a professor of public health nursing at the university.

MARIE: I have been offered a position in the high school in Callander, teaching a Perfect Parent Course.

DR. LADIEUX: Ah, then you will be near *me*—that is good!

YVONNE (*giggling*): I hope to *be* a perfect parent.

DR. LADIEUX: Ah, ah! Is that young man still in evidence?

(*The girls laugh*).

CECILE: Ask her if she has a date tonight!

EMELIE: I want to work with poor children—the *dirtier*, the *better*—and help them get the kind of care *you* gave *us*.

DR. LADIEUX (*patting Emelie's hand*): Merci, Emelie. Well, now at last you will all be separated for the first time in your lives. I shall be interested to see how you develop without each other.

MARIE: But first, papa, before we begin our work, we have planned to take a vacation at Lake Louise.

CECILE: Yes, and you are to come with us.

ALL (*enthusiastically*): Yes! yes!

EMELIE: We've been away from you *so long*, we just have to have you with us.

DR. LADIEUX: How delightful! And I have always wanted to see Lake Louise.

YVONNE: We shall have a wonderful time, but we won't drag you around too much. You can have a good rest.

DR. LADIEUX (*pensively*): Yes, now I can rest; my babies are grown up, and able to take care of themselves—and *others* too. But (*brightening and looking at the girls*) shall we go now to the garden and have a cup of tea, yes?

ALL (*together*): Oh, yes! yes!

(*The girls assist the doctor gently from the couch and he, walking feebly, goes with them off-stage*).

CURTAIN

NARRATOR: And here we leave you with the story of the most wonderful babies in the world. They are now telling Dr. LaDieux of their plan to erect and endow a University School of Nursing in Callander, as a monument to their dear old friend and counselor, Dr. LaDieux.

FINIS.

Character Make-up—Courtesy, Max Factor's Hollywood Studio.

SEXTETTE WELCOMES N.O.P.H.N.

A sextette in Spanish costumes sang three songs between the first and second acts of the skit: *Song of Welcome*, with original words sung to the tune of *The Bells of St. Mary's; I Love You California;* and *Celieto Lindo*. The singers were accompanied by Olvera Street players—from the picturesque little Mexican street in Los Angeles, where many nurses bought Mexican wares.

Four members of the sextette were nurses from the Bureau of Public Health Nursing, Department of Health, County of Los Angeles; and one was from the Board of Education, City of Los Angeles. The singers were: Mrs. Esther Tavonier, leader, Kathryn Chance, Irene Wheeler, Catalina Godman, Frances Virginia Phillips, and Guadalupe Spencer.

SONG OF WELCOME

Tune: The Bells of St. Mary's

The nurses of California
Extend you a welcome,
The key to Los Angeles
Is yours while you stay.
The Thirtieth Biennial
We'll always remember—
New friendships made,
And knowledge gained,
For you and me!

We urge all to join now,
Our Organization,
Let's make Public Health Nursing
The pride of the Nation.
We need you, they need us
(Spoken with emphasis)
In each situation,
So join our throng
Ten thousand strong.
N-O-P-H-N!
(Shouted like a college yell).

Public Health Nursing Under the Social Security Act

DEVELOPMENTS UNDER THE CHILDREN'S BUREAU*

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THE responsibility for the administration of Parts 1, 2, and 3 of Title V of the Social Security Act was entrusted to the United States Children's Bureau in August, 1935, by Act of Congress. This title provides for maternal and child health services, maternal and child welfare services, and services for crippled children, through the authorization of annual appropriations to the states, a large proportion of which must be matched by the states.

In order to clarify the implications for public health nurses** in the health activities growing out of this federal legislation, the provisions of the parts of the title administered by the Children's Bureau will be partially quoted.

PROVISIONS FOR CHILD WELFARE

Part 3 provides for child welfare, as distinguished from child health, in that it specifies that federal funds be used "to coöperate with state public welfare agencies in establishing, extending, and strengthening, especially in predominantly rural areas, public welfare services . . . . for the protection and care of homeless, dependent, and neglected children and children in danger of becoming delinquent."

Public health nurses will wish to be thoroughly familiar with the programs of their various states in regard to social provisions for mothers and children, including the programs established under Title IV, Grants to States for Aid to Dependent Children, which is administered by the Social Security Board, for the nurses will often find points of contact affecting the families under their care. However, the most direct implications for public health nursing services lie in the provisions of Parts 1 and 2 of Title V of the Social Security Act.

PROVISIONS AFFECTING PUBLIC HEALTH NURSING

Part 2 of the Title, Maternal and Child Health Services, authorized federal appropriations "for the purpose of enabling each state to extend and improve, as far as practicable under the conditions in such states, services for promoting the health of mothers and children, especially in rural areas and in areas suffering from severe economic distress."

Part 3 of this Title, Services for Crippled Children, authorizes the appropriations "for the purpose of enabling each state to extend and improve (especially in rural areas and in areas suffering from severe economic distress), as far as practicable under the conditions in each state, services for locating crippled children, and for providing medical, surgical, corrective, and other services and care, and facilities for diagnosis, hospitalization, and aftercare for children

*This article is published in lieu of the address given by Miss Deutsch at the N.O.P.H.N. General Session, Biennial Convention, June 26, 1936, since it was prepared for PUBLIC HEALTH NURSING just prior to the Convention and covers the same subject matter as the Convention address.

**See also Eliot, Martha M., M.D., "The Federal Program for Social Security." PUBLIC HEALTH NURSING, December 1935.

who are crippled or who are suffering from conditions which lead to crippling."

In the state programs which are developing as a result of provisions incorporated in Parts 1 and 2 of Title V, the potentialities for public health nursing service are manifold, particularly in the preventive field in rural areas.

Within the Children's Bureau the organization and personnel especially set up to facilitate advisory and consultative service to states in carrying out the social security provisions related to the health of mothers and children are as follows:

A Division of Maternal and Child Health, under the direction of a physician

A Division of Crippled Children, also under the direction of a physician

A Unit of Public Health Nursing, for administrative purposes placed under the Division of Maternal and Child Health but meant to serve both divisions named above, as well as the Child Welfare Division, which is under the direction of a social worker.

Through a small staff of medical consultants and a small staff of public health nursing consultants, advice and consultation on maternal and child health and crippled children will be made available to the states on a regional plan, the regions covered by the public health nurses conforming to those covered by the medical consultants. The field staff of the Child Welfare Division will operate on a similar plan.

In addition, there is a nutritionist who is available for assistance in regard to that aspect of the maternal and child health program represented by her specialty.

The Unit of Public Health Nursing now consists of a staff of four: a director and three field consultants. The addition of two more public health nurses is anticipated within the next two months.

Ever since the creation of the Children's Bureau in 1912, public health nurses have figured in its activities. As a matter of fact, the idea which motivated the establishment of a federal agency concerned solely with the interests of children is ascribed to Lillian D. Wald, long a leader in nursing ranks.

Public health nurses from time to time have been part of the Children's Bureau staff in connection with special programs for child health. Some of the activities with which they were specifically identified were: the "Baby Week" campaigns of 1916 and 1917, which took the form of popular educational programs carried on in the various states with the coöperation of the General Federation of Women's Clubs; and the "Children's Year" programs of 1918 and 1919, which also represented a coöperative enterprise with the Child Conservation Section of the Field Division of The Council of National Defense. During the war and post-war days names of a number of prominent nurses were associated with the Children's Bureau.

Public health nurses throughout the country have long been aware of and identified with program and research sponsored by the Bureau. Its publications in the field of maternity and child health and management have been widely used to supplement public health nursing instructions in homes and health centers.

In 1921-29, when the Sheppard-Towner Act was in effect, public health nurses were extensively involved in state and local programs for maternal and child health made possible through this legislation. In many states where units for the administration of Sheppard-Towner services were created within state health departments, public health nurses and other personnel have remained to function in this field.

SCOPE OF NEW SERVICES

And now again, in 1936, public health nurses will be needed to a large extent to help carry out health measures resulting from state and local application of social security provisions. These services will differ from those provided for under the Sheppard-Towner Act in that their scope will be enlarged to include children beyond the preschool age; the crippled child is to receive particular attention; and there is to be very special emphasis on the rural areas and smaller communities. Practically all the states, as well as the Territories of Alaska and Hawaii, now have bureaus or divisions of maternal and child health within their state health departments, and plans for officially supported pro-

grams for the care of crippled children have been completed in all but seventeen states. This is significant because the Act particularly designates the state health department as the responsible agency for the maternal and child health program, whereas the program for crippled children may be administered by one of several types of official agencies: the departments of health, of public welfare or education; a state commission concerned especially with the care of handicapped children; or in a few cases the state university hospital.

So much for the administration of Title V of the Social Security Act from the standpoint of public health nursing interests, and the part that public health nurses have taken in previous health activities of the United States Children's Bureau.

CONDITIONS RESPONSIBLE FOR NEW MEASURES

This brings us to a review of the conditions which brought about the inclusion in the Social Security Act of special provisions for mothers and children, in addition to general measures for economic security of the family which also have a bearing upon the welfare of children. In general, some of these conditions are:

The number of crippled children in the United States, which is estimated at 300,000 to 500,000

Our high maternal death rate, with its tragic consequences to children

The unnecessarily great loss of babies during their early weeks and months of life.

The establishment of new resources and the extension and improvement of those already existing for remedying and preventing conditions so grave in nature and proportion has become a serious responsibility of the community; hence, of the government:

The challenges to public health nurses are clear and urgent. By virtue of their function as health teachers and interpreters, they are closely in touch with many families and with the health organizations and institutions which exist for them They are in a strategic position to help improve these conditions. However, in order to accept these challenges conscientiously public health nurses not only must acknowledge the problem and desire to help with it, but must also frankly take stock of the professional equipment through which they can contribute. Public health nurses have been brought face to face, through a recent survey, with findings favorable and unfavorable about themselves—their organizations, program, and performance.*

DEFICIENCIES SHOWN BY SURVEY

All factors in the administration and practice of public health nursing, as well as professional qualifications of personnel, have a direct bearing on services for mothers and children, but a few of the survey findings have specific significance in relation to these services. Some of them, which strikingly reveal the need for further search for causes and for methods of improvement, are as follows:

Little provision has been made for nursing service at the time of home delivery, for which it seems logical that public health nursing agencies assume responsibility in order to assure complete and continuous health protection for mother and baby.

The provision through public health nursing agencies for assistance with arrangements for medical examinations of mother and baby at the end of the six-week postpartum period are shown to be inadequate.

Public health nursing agencies on the whole have too little information in regard to the stage of pregnancy at which women come under care—information which is highly important from the standpoint of making early contact for prenatal care.

The quality of performance in the field of health supervision of preschool children ranks low in comparison with other types of public health nursing service.

Service to school children was shown to be lowest in quality, as analyzed according to methods used for other public health nursing services.

ENCOURAGING ASPECTS

A more heartening revelation lies in the fact that prenatal care ranks highest in performance of all services given by public health nurses and that such care is almost always included in community

*National Organization for Public Health Nursing. *Survey of Public Health Nursing*. The Commonwealth Fund, New York, N. Y., 1934.

programs of public health nursing. One of the possible reasons ascribed for this relatively high performance is that there have been special federal and state appropriations for promoting and extending maternal care, and that it has consequently been given special emphasis in public health nursing services. Public health nurses and other health workers have been able to enlarge their knowledge and strengthen their practices through special educational direction and supervision made possible through these federal and state appropriations.

This is an interesting conjecture in the light of present provisions of the Social Security Act. If effective results were demonstrated in one phase of maternity nursing service, through former federal and state assistance, why should we not, with our present resources, be able to show equally effective results in a complete maternity nursing service? Through closely coördinated efforts of the federal and state agencies administering the health provisions of the Act, this should be possible. With carefully planned educational resources made available, a greater number of public health nurses working under improved educational direction and supervision provided through social security funds will be better prepared to accept these further challenges.

DEVELOPMENTS UNDER THE U. S. PUBLIC HEALTH SERVICE*

By PEARL McIVER, R.N.

Senior Public Health Nursing Consultant, U. S. Public Health Service, Washington, D. C.

TITLE VI of the Social Security Act is designated as the Public Health Section of that Act. The law specifies that the administration of this title shall be the responsibility of the U. S. Public Health Service. The extension of public health services under the provisions of the Social Security Act does call for new activities on the part of the Public Health Service.

The Bureau now known as the Public Health Service was established by Act of Congress July 16, 1798. At that time it was known as the Marine Hospital Service and its chief function was to provide medical care for disabled seamen. The medical men employed by the Marine Hospital Service were stationed at the various ports of entry to this country, and they were frequently the first to diagnose diseases such as cholera, yellow fever and smallpox, which from time to time threatened the welfare of the people at the ports of entry. During epidemics, the Marine Hospital Service frequently received Presidential authorization to aid local health authorities. Thus, the duties and responsibilities of the Marine Hospital Service grew; and in 1902, in keeping with the rapidly developing science of public health, Congress changed the title to the Marine Hospital and Public Health Service. In 1912, it was officially designated as the U. S. Public Health Service.

The principal functions of the Public Health Service, as carried out today, are as follows:[1]

1. To defend our country against the introduction of disease from abroad. This is accomplished by stationing medical officers at the various consular offices abroad to prevent persons suffering from communicable diseases from being transported on vessels bound for the United States; by stationing officers at the ports of entry to inspect all boats before disembarking; and by coöperating with the local health authorities at the port of entry by reporting infectious diseases which are not quarantinable.
2. To control the interstate spread of communicable disease. The state health authorities are responsible for the control of disease within their respective states, but with the vast amount of transcontinental travel which has been developed it is necessary to have some federal agency responsible for the control of disease which may be spread through transportation of persons from one state to another.

*Presented at the N.O.P.H.N. General Session, Biennial Convention, Los Angeles, California, June 26, 1936.

3. To supervise the manufacture of biological products (serums, vaccines, etc.) and to license the manufacturers of these products.
4. To study the cause, means of propagation and spread of diseases of mankind. The National Institute of Health, located in Washington, D. C., is one of the best equipped research laboratories in the world. A considerable number of field as well as laboratory studies are under way at all times.
5. To furnish medical, nursing and other personnel necessary to operate the marine hospitals, the federal narcotic farms, and the medical service of the federal prisons.
6. To coöperate with state and local health departments in all matters pertaining to public health by furnishing technical consultants and assisting in the organization and maintenance of local health work.

NURSING CONSULTANTS

For many years, the Public Health Service has provided consultants to state health departments in public health administration, epidemiology, environmental sanitation, malaria control and various other public health specialties. Public health nursing was added to the consultant services in 1934. The need for consultants in public health nursing became evident when numerous requests began to arrive from the state for assistance in the development of plans for the federal emergency relief nursing programs. However, the services of the nursing consultants were not devoted wholly to the emergency work relief programs. Their chief function has always been to stimulate and to aid in the organization of permanent public health nursing services in all state health departments. Considerable progress had been made in this direction even before the Social Security funds became available.

When one examines the provisions of Title VI of the Social Security Act, it will be seen that the public health provisions of the Act are not new theories; and that with the exception of the provision for the training of public health personnel, the same functions have been carried out by the Public Health Service in coöperation with the several state health departments for a number of years. However, the money available for these functions was extremely limited in the past. The appropriations authorized by the Social Security Act make it possible to carry out these functions on a much broader and, we believe, a more effective scale.

There are two main purposes of the public health title of the Social Security Act. The first is to aid in the establishment and maintenance of adequate state and local health services. The training of public health personnel is specifically mentioned as one of the problems incidental to the establishment of adequate health services. The second purpose is to conduct studies and investigations of disease and problems of sanitation. The first purpose will be accomplished through grants-in-aid to the several state and territorial health departments. The studies and investigations of disease and sanitation will be done under the immediate direction of the U. S. Public Health Service.

The Social Security Act authorized Congress to appropriate eight million dollars annually for the establishment and maintenance of adequate health services and for the training of personnel. An appropriation of two million dollars annually is authorized for the studies and investigations of disease and sanitation.

BASIS OF ALLOTMENT OF FUNDS

The Social Security Act specifies that the public health funds which are to be allotted to the states shall be allotted on the bases of population, special health problems and the financial needs of the several states. The Surgeon General of the Public Health Service is charged with the responsibility for allocating the funds to the states and with the preparation of regulations governing the payments from allotments. However, the Act specifies that the Surgeon General shall confer with the state and territorial health officers before making the regulations. This is a wise provision and insures a method of payment which will meet with the approval of the majority of the state health departments.

In accordance with the recommendations made by the Conference of State and Territorial Health Officers, fifty-seven and one-half per cent of the total

appropriation for aid to the states will be allotted on the basis of population. New York State gets the largest share of this allotment, inasmuch as it has the greatest population. Funds allotted on the basis of population must be matched by state or local health funds.

Twenty-two and one-half per cent of the total appropriation made for state aid will be allotted to the states on the basis of special health problems, including the training of personnel. The training of a sufficient corps of public health workers to carry out the provisions of the Act is a problem which confronts every state; and twelve and one-half per cent of the total appropriation will be used to assist in the establishment of regional public health schools, and for the payment of tuition, traveling expenses, and living stipends of the public health trainees.

In addition to the problem of securing adequately prepared public health personnel, many states have special health burdens, such as malaria, hookworm, typhus fever, bubonic plague, hazards connected with industry, and the problem of the migratory tuberculous patient. The remainder of the allotment made on the basis of special health problems will be allocated to those states which have special problems.

The third basis for the allotment of funds to the states is the financial needs of the respective states. Twenty per cent of the total appropriation will be allotted on this basis. Per capita income was selected as a fair basis for determining the financial needs of a state. On this basis, the states having the lowest per capita income get the largest percentage of this allotment. The funds allotted to a state on the basis of financial needs do not need to be matched by state or local funds.

To be eligible to receive allotments for public health work from Social Security funds, each state is required to:[2]

1. Present a comprehensive statement of the present state health organization, its program and budget.
2. Present a proposed plan for strengthening and improving the administrative functions of the state health department.
3. Present a proposed plan for extending and improving the administration of local health services.
4. Present a statement of the health services to be carried out under the provisions of Title VI of the Social Security Act.

The plans submitted by the several states are reviewed by the Surgeon General and approved if the general policies involved are considered to be sound. It is not the aim of the Public Health Service to encourage the establishment of identical health programs or types of organization in every state. The problems and needs of different states vary and consequently the programs designed to meet those needs must necessarily vary. However, there are a few standard principles of organization which health administrators believe should be upheld regardless of location or conditions. The Conference of State and Territorial Health Officers recommended that every state health department should:[3]

1. Be under the direction of a qualified full-time health officer.
2. Provide for the administrative guidance of local health services. (Since all local health services employ public health nurses, every state is expected to include public health nursing as one of its consultant services.)
3. Provide an acceptable vital statistics service.
4. Furnish a state public health laboratory service.
5. Provide adequate services for study, promotion, and supervision of maternal and child health.
6. Provide facilities for the study and control of preventable diseases.
7. Provide services for study, promotion, and supervision of environmental sanitation.

LOCAL HEALTH SERVICES

With regard to local health services, the Conference of State and Territorial Health Officers recommended that local health services be organized on a county, city, or district basis in accordance with the size of the area and the population to be served. The Conference further recommended that all local health services be under the direction of a whole-time health officer and that the number of public health nurses and other personnel employed be commensurate with the needs of the area to be served. The Conference was of the opinion that all personnel should meet the professional qualifications which

were recommended for each type of worker by the Committee on Qualifications for Health Officers and Personnel.

This type of local health service is available to only a small part of the rural population of the United States at the present time. About twenty-seven per cent of the rural population have health services which are under the direction of whole-time health officers.[4] However, the amount of nursing service available in many of these counties has been very inadequate. The average population per nurse in the organized county health departments of the United States is about 20,000, according to the study of rural health work which was made under the auspices of the Committee on Administrative Practice of the American Public Health Association.[5] The ratio of one public health nurse to each 2000 of the population has frequently been suggested as a desirable goal.[6] It is quite evident that there is need for a large number of additional public health nurses before the number of nurses employed by the health departments already in existence is "commensurate with the needs"—not to mention the vast areas which, at the present time, have no public health service of any type.

OPPORTUNITIES FOR PUBLIC HEALTH NURSES

Local health departments

Will Social Security funds be used to supply additional public health nurses for local areas? An analysis of the budgets which were submitted by the several state health departments to the Public Health Service for the last five months of the fiscal year 1936 shows that about seventeen per cent of the total amount of money paid into each state (exclusive of training funds) was budgeted for public health nursing in local health departments.* This is all the more significant when it is remembered that a large percentage of the Social Security funds appropriated for maternal and child welfare will also be budgeted for local public health nursing service.** The regulations provide that Social Security funds must not be used to relieve a local or state agency from paying for a service which it has heretofore supported. Therefore, according to the budgets which are now in effect, all or a part of the salaries of a considerable number of additional local public health nurses are being paid from Social Security funds which were appropriated for general public health work.

State health departments

In 1934 when the public health nursing consultation service was established in the Public Health Service, there were sixteen state health departments which employed no public health nurses for any purpose. In some of the states public health nurses were employed to inspect baby-boarding homes or to render direct service to unorganized counties, but no public health nursing consultation service was rendered to local health agencies. Practically all of the state health departments have made provision for a public health nursing consultation service in their present budgets.

Inasmuch as the Children's Bureau and the Public Health Service have agreed to recommend that public health nursing within a state health department be organized as a unit, most of the states are setting up the public health nursing service as an activity supported by funds from both federal agencies. Not all of the consultant nurse positions in state health departments which are provided for in the budgets for this fiscal year have been filled, because it has not been possible to find qualified public health nurses. These positions for state public health nursing consultants are key positions and it is desirable that the nurses appointed possess, in addition to unusually high professional qualifications, personal qualifications which will enable them to win the confidence and respect of other state and local health workers. The opportunities open to nurses in state health departments offer a distinct challenge to the nursing profession.

*Funds appropriated to carry out the provisions of the Social Security Act became available February 1, 1936.

**Maternal and child welfare funds are administered by the Children's Bureau, U. S. Department of Labor.

Federal nursing services

To aid in the administration of Title VI of the Social Security Act, the Public Health Service has divided the country into five health districts. The headquarters for the respective health districts are as follows:

Northeastern—New York, New York
South Atlantic—Washington, D. C.
South Central—New Orleans, Louisiana
North Central—Chicago, Illinois
Western—San Francisco, California

Medical, engineering, and public health nursing consultants have been assigned to each district to assist the state health departments in the development of this program. The services of the consultants are advisory in character, and no service will be rendered in any state except upon the request of the state health commissioner. The duties of the public health nursing consultants may include any or all of the following functions:

1. To advise state health administrators on the organization and administration of public health nursing services.
2. To assist the state public health nursing directors in planning the educational programs for public health nurses.
3. To assist the public health nursing courses by keeping them informed about the needs of the states and by interpreting the standards and requirements of the courses to the several state health departments.
4. To conduct institutes for groups of public health nurses or public health nursing supervisors on subjects pertaining to general public health nursing.
5. To assist in interpreting the policies and plans for the developments authorized by Title VI of the Social Security Act to lay or professional groups, through lectures and round-table discussions.

The public health nursing consultants of the United States Children's Bureau and of the Public Health Service are working in close coöperation. Joint plans for the organization and administration of public health nursing have been agreed to by the two bureaus and a close working relationship has been established.

In an address which Dr. C. E. Waller made at the annual meeting of the Southern Branch of the American Public Health Association in St. Louis, Missouri, in November, 1935, he said, "Without doubt the most important step in the whole program of organization [under the Social Security Act] will be providing, first of all, adequately trained personnel to do the work."[7]

For a number of years, the nursing profession has been conscious of an oversupply of graduate nurses. However, when the opportunities for increased service were presented, there were "too many and yet too few."[8] Funds for the postgraduate preparation of public health nurses are available, but a number of the states are finding it difficult to locate nurses who can meet the matriculation requirements of the public health nursing courses. In other words, we have an oversupply of nurses, but a considerable number of the graduate nurses are unable to meet the minimum requirements for admission to a public health nursing course. These requirements include:

1. Graduation from an accredited high school.
2. Graduation from an accredited school of nursing connected with a general hospital which had a daily average of fifty or more patients.
3. Good health and personal qualifications which indicate an aptitude for public health nursing.

During the last five months of this fiscal year, fellowships for postgraduate training in public health nursing were given to 356 graduate nurses from 36 different states. The fellowship awarded to each trainee includes tuition fees, traveling expenses to and from the institution selected for training, and a living stipend. The Public Health Service has recommended that the maximum stipend for all types of trainees who do not have dependents be one hundred and twenty dollars per month.

A survey of the living expenses at the different colleges and universities indicates a considerable variation in living costs. Most of the state health departments are taking this into consideration and are paying stipends in accordance with living costs at the institution selected. The stipends which were paid this spring varied from seventy to one hundred dollars per month.

It is believed that those trainees who

are selected for an entire academic year's work should receive a slightly higher stipend than those who register for a shorter period. Additional expense, such as insurance premiums, which may not have to be met by those who enroll for but one semester's work, will often have to be paid out of the living stipends if the student remains in school for a whole year.

State health departments are privileged to select as a training center for students any course of study which meets the requirements recommended by the National Organization for Public Health Nursing. The Public Health Service believes that the existing courses in public health nursing which meet these requirements should be utilized to their fullest capacity before additional public health nursing courses are established. An exception to this policy was made in connection with the establishment of the public health nursing course for Negro nurses at the Medical College of Virginia in Richmond, inasmuch as none of the existing public health nursing courses in the South admitted Negro nurses.

The funds which have been allotted to each state for the training of personnel will yield rich returns if the persons selected for training are carefully chosen. The directors of the public health nursing courses to which Social Security trainees were sent this spring have offered a number of suggestions which should be helpful to the state health administrators in selecting trainees for next year. The directors of the public health nursing courses agree that:

1. The nurses selected should be able to meet the entrance requirements of the college or university. However, a very limited number of experienced nurses who have proven their ability in the field may be admitted as special students upon the recommendation of the state public health nursing supervisor.
2. It would be wise to select nurses who have demonstrated their ability either in the field or as public health nursing students.
3. Preference should be given to nurses who have had, during their basic nursing courses, exceptionally good clinical experience in obstetrics, pediatrics, and communicable diseases.

PERMANENCY OF PROGRAM

The Social Security Act is not an emergency measure. It is designed for the purpose of developing a permanent program of social betterment. However, the appropriations authorized by the Act must be made by Congress on an annual basis. Whether Congress will continue to appropriate the funds authorized by the Social Security Act will depend in a large measure upon the results which are accomplished. Increased opportunities always mean increased responsibilities. Federal, state and local health agencies which are responsible for the administration of this program must accept the challenge and show that they are capable of doing a good job. If all health workers—including health officers, engineers, nurses, and others—accept as a common objective *the development of a well rounded public health program,* and if all personnel are appointed on the basis of merit and not because of politics or personal favoritism, it will not be difficult to convince appropriating bodies that public health is both a social and an economic necessity.

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N.O.P.H.N. 1936*

By AMELIA GRANT, R.N.

IT is not unusual to think that whatever we are facing is of particular importance, but before us at this time seems to be a very interesting challenge and an opportunity for real service which brings satisfaction in our work. These new responsibilities and opportunities which we see before us bring us great enthusiasm for moving ahead and we hope that we may contribute to this movement in a sound and profitable way; but they also give us a feeling that perhaps certain changes are taking place, and that we should be very thoughtful in our planning not only for today and for the next few years but possibly for a long period in public health nursing.

The N.O.P.H.N has had almost twenty-five years of experience in helping to guide public health nursing through a period of very rapid growth and development. During this time a body of fundamental principles has been built up. These principles seem sound, and we believe they can be relied upon as a reasonably secure basis for further development. It is necessary, however, to continue to study every new situation and to test these principles—guarding against any confusion between routines or practices, and principles. New issues should be met with such adaptations as seem best. The N.O.P.H.N.'s organization and plan of work through committees tend to give it a breadth of view and contact with the problems of the field which are vital factors in making it a useful organization.

Now there are, as I have mentioned, certain changes in thinking or attitude concerning social responsibilities which seem to be taking place and these obviously must be considered in our present planning. Due perhaps more to the economic situation than to a carefully thought-out and well understood social philosophy, there is a trend toward the expansion of public service under official auspices. The expansion of public health nursing under governmental administration has come rather suddenly and rapidly.

The shift in administrative control brings to us a very definite new responsibility. It certainly does not mean a release of responsibility for the private public health nursing agencies, but rather an even greater and perhaps more difficult task—that of seeing to it that the transition takes place without loss of quality of service. New and larger informed groups are needed to take such action as will safeguard, improve and forward the quality of service under government administration.

NEW LAY RESPONSIBILITIES

Who can better help to develop the right type of nursing in official organizations than the lay people who have served as board members of the private agencies? They have studied the nursing needs; they know desirable standards of work; they know accepted qualifications of personnel and what it costs to maintain a nursing service; and further, they know the value of good nursing service to the community. It is not difficult for this group to visualize what it is that the public health nurse should do for the families in the community, and they have a way of reaching other people in the community which is perhaps not as readily open to those of us in the professional group. These facts, which are known to the private agencies, need to be interpreted to the larger body of citizens who, by their interest and understanding, control in a large degree the quality of service to be provided under official direction. In a very real sense the quality of any governmental service is determined by the interest of the citizens.

Our lay members' section has there-

*Report of the President, presented at the N.O.P.H.N. opening Business Meeting, Biennial Convention, Los Angeles, California, June 22, 1936.

fore a definite and constructive part to play in this changing program. It is a group with an interest in community service, and will be able to assist private organizations to adjust their services and correlate them with the work of the official agencies; to help in keeping a balanced program so that no important service will be denied the community; and to continue to demonstrate and prove the value of certain types of work. They may even advise that private organizations appoint to membership on their own boards and committees those people in the community who can directly assist in maintaining a high type of public health nursing in the official agency, in the hope the experience in the private agency may be of value indirectly in influencing the standards of work in the public agency.

The selection of personnel in official agencies is an important factor for present consideration. The expansion of public health service under the Social Security Act will in itself bring this matter more frequently and more urgently to the attention of the N.O.P.H.N. We have had for some time a Committee on Personnel Practices in Official Agencies, but only recently have we been able to undertake a study of these existing practices in state, county and municipal services. It is necessary to have more information concerning current practices, and the results of this study will be used as the facts are gathered and compiled.

NEW OPPORTUNITIES

Before leaving the subject of the N.O.P.H.N.'s service in helping to develop and maintain standards of work under governmental administration, it seems important to mention that we need to do our part in making these positions in official agencies attractive and satisfying, and further that we need to interest capable nurses in taking such positions. We need to direct thinking toward government-service as a career worthy of the best effort.

Expansion of service brings with it the need for more nurses, and of course emphasizes the problem of their preparation. The Education Committee of the N.O.P.H.N. has new problems because of the present public health nursing situation and because of certain changes which are taking place in the basic preparation of nurses. The committee is working closely with the National League of Nursing Education in regard to the preparation of the new curriculum for schools of nursing, and is thinking through the changes in the postgraduate public health nursing curriculum which will follow the changes in the basic course.

It is also considering the problem of the preparation of public health nurses in certain fields for which they are not now well prepared because of relatively less opportunity or demand. The greater interest in social hygiene and orthopedic service as a part of public health programs is creating a need for nurses with more thorough preparation in these fields.

A certain number of well prepared nurses in special fields seems to be needed even though the generalized plan of work is followed. Also, staff education or training in the field needs to be developed further, and practice fields for public health nurses in training need to be considered. I think the Education Committee is well aware of these problems and is already working on them.

The Committee on Administrative Practice and Public Relations has changed its title from that of the Field Studies Committee, because the former name seems more nearly to define its scope and function. It is chiefly concerned with administrative practices essential for good nursing performance, and the relation of public health nursing to all other public health activities. The work of this committee is closely correlated with the work of the Committee on Administrative Practice of the American Public Health Association. This tie-up provides for the N.O.P.H.N. a very necessary and highly valuable contact, and gives greater strength and practicality to its advisory service.

While we are deeply concerned with the varied problems of administration, education and nursing standards, we

are after all primarily concerned with providing for everyone in the community adequate nursing service according to his needs. It is a bit paradoxical that people are unnursed, and at the same time nurses are without employment. The situation has been the concern of the three national nursing organizations for some time, and for this reason, a Joint Committee on Community Nursing Service was formed. The purpose of the committee is to analyze existing needs for more satisfactory nursing service throughout the country, and to consider, through study and possibly experimentation, new means for meeting these needs. The committee now has a full-time secretary to carry on the studies and to assist communities, through consultation and advice, to meet the need for planned, related and more complete nursing service—whether it be for more public health nursing, hourly nursing, full-time private duty nursing, or whatever type seems indicated. It is hoped that the progress made in a few selected localities will stimulate interest and action in other communities.

So many are the fields of service in which the N.O.P.H.N. might use its resources and efforts that it has seemed time to have a rather thorough stock-taking to determine which are its first and primary functions; and further, how a sound financial basis may be developed, so that these activities may be carried on within its probable budget—which is essential if we are to be assured of permanency.

Two committees are studying these problems—the Ways and Means Committee, concerned with financing the work of the N.O.P.H.N., is just being organized and is not yet really active; the Committee to Study the Functions of the N.O.P.H.N. *is* actively at work. Its plans and recommendations will, of course, take into consideration recent developments under the federal government. With the appointment of public health nurses to the staffs of the U. S. Public Health Service and the Children's Bureau, these governmental bureaus are giving a field advisory service which is national in scope, and which has the same objectives and standards as those of the N.O.P.H.N. This will no doubt relieve the N.O.P.H.N. of the necessity for a certain amount of its field service; but it also creates a need for a program coördinated with the work of these federal agencies and for new relationships to be defined and worked out to the advantage of all. It is a great comfort to know that, with so many demands for help with local problems, additional service is now available through these federal agencies.

PRESSING NEEDS

The N.O.P.H.N sees a need for extending its service and giving more time to certain problems. The next step, as seen at present, is for increased activities in school nursing and industrial nursing fields. With the further development of full-time health services in counties, and wider acceptance of the idea that the family is the unit to be considered in a health service, the relationship of the school program to other health services must be considered. It is true that great advances have been made in thinking through the school's responsibilities for health, and the place of the various members of the school staff—teachers, physical educators, physicians and nurses—in the coordinated health service. But there is much left to be done.

The Board at its last meeting agreed that there is need for an additional N.O.P.H.N. staff member who would devote her time to study of and assistance with the many questions concerning school nursing which are arising. It is hoped that the budget may permit such an addition to the staff.

Almost, if not equally important, is the need for the study of industrial nursing problems and more active participation in this field of nursing. With the return of greater industrial activity will come extension of the industrial health services, and, no doubt, wider interest in utilizing the approach through industry to certain of our recognized health problems. The relationship of industrial health service to the larger

community health service, and the contribution of the nurse in the field, suggest many questions on which the N.O.P.H.N. should give some guidance.

Other studies which bring together facts and recommendations to strengthen public health nursing as an organized program, and to give—directly or indirectly—assistance to individual nurses, must be carried forward. The outlook presents a picture of the N.O.P.H.N being in a position of great usefulness. It has machinery set up, through the organization of its committees, to meet these various problems. Certainly we think we have a point of view which should make it possible for this organization to contribute to the development of public health nursing and to help nurses meet their opportunities for sharing in the larger program of social welfare.

MAY WE PRESENT

VIRGINIA A. JONES

As announced in the July issue of the magazine, Miss Jones will join the N.O.P.H.N. staff on September 15 to be in charge of educational activities including the secretaryship of the Education Committee. It is with pleasure that we introduce her to you.

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Agnes G. Talcott, R.N., Los Angeles, Calif.
Estella Ford Warner, M.D., Washington, D. C.
Mrs. James K. Watkins, Detroit, Mich.

Term Expires 1940

Mrs. Joseph S. Barker, Cincinnati, O.
Mrs. Charles S. Brown, New York, N. Y.
Naomi Deutsch, R.N., Washington, D. C.
Mrs. William E. Hale, South Pasadena, Calif.
I. Malinde Havey, R.N., Washington, D. C.
Olivia Peterson, R.N., Minneapolis, Minn.
Marguerite Wales, R.N., New York, N. Y.
W. F. Walker, Dr.P.H., New York, N. Y.

Biennial Report of N.O.P.H.N. Activities*

By DOROTHY DEMING, R.N.
General Director

HAVE you ever been walking hurriedly along the street and suddenly noticed something in a store window which you just must have —something that is just right in size, color, or price? You stand there debating a moment and then dash in recklessly and make your purchase. This is just the situation the N.O.P.H.N. is in all the time, *with one important difference*. We always have to turn firmly away! There is hardly a day when some exceedingly desirable and suitable service does not tempt us to spend your money. But we refrain, knowing that we have barely enough money in our budget to carry on the accepted program, and that reckless spending is not compatible with sound corporate business, whatever it may be in a personal budget! I think that as shareholders in this company, you ought to know some of the desirable services we are failing to give you. With difficulty, I have picked out six of the most important from a large and tempting collection.

1. We believe you would like to have public health nursing correctly interpreted, prominently but ethically featured and more generally used in all the health activities of organized groups—particularly those groups with national parent bodies, similar to the N.O.P.H.N. We have barely touched this field of promotion for you. Basic work has begun with the government agencies, but wider opportunities are being offered every day to work with such groups as the National Education Association, the National Congress of Parents and Teachers, the General Federation of Women's Clubs, the National League of Women Voters, as well as the national bodies more specifically concerned with health. The N.O.P.H.N. needs the means for continued, effective and timely interpretation of public health nursing. There is evidence in all these groups of great receptivity and of more genuine interest and desire to work with us than I can remember in the nine years I have been with the N.O.P.H.N. —if we can only find the time and staff to present our program! Can you see how this would help you? Let me give you one example.

Recently, the National Congress of Parents and Teachers wanted to draw up a handbook on the Summer Round-Up. A member of the N.O.P.H.N. staff was on the Advisory Health Committee of the National Congress of Parents and Teachers. She was asked to write briefly what the public health nurse's duties should be in the Summer Round-Up. That leaflet is finding its way into every local parent-teacher association. What it says about public health nursing is what you would like to have it say. The duties listed are those ethically and educationally desirable, and it carries authority with the parent-teacher associations because it is their national pronouncement. To stamp our imprint on this type of health procedure, to get back of the scenes, to explain public health nursing to the policy-making groups of other agencies, to promote it through the spoken and written word at key points—our own magazine not excepted—don't you want us to do this for you and the public health nursing movement as a whole?

2. We believe you would like to have us gather more information and be more helpful to you on this question of which we talk so much; namely, the relation of public to private agencies. Using the term "private agency" in its widest sense, what should be the relationships between nurse registries, visiting nurse

*Presented at the opening Business Meeting of the N.O.P.H.N., Biennial Convention, Los Angeles, California, June 22, 1936.

associations, and the out-patient services of hospitals?

May I present a few of the questions we cannot answer for you now. Who should do hourly nursing—the registry or the visiting nurse association? Should visiting nurse associations supervise the work of "practical nurses"? Should city health department staffs offer practice fields to graduate and undergraduate students? What kind of joint public and private staff education programs are successful? Where are public agencies sharing special consultants in their work? Where are they using citizens' advisory committees effectively? How can private agency boards aid health department staffs to attain their goals? Should members of private agency staffs be on the civil service lists? When should the private agency turn its work over to the health department, how much of it should be turned over, and what are the first steps? There is a crying need for us to be intelligent in regard to this general relationship since we serve both groups continually.

3. Then there is the field of education of public health nurses. Certainly the N.O.P.H.N. must hold its place here. Analyzing our program critically, I should say our best work and most valued contribution have been in this field. We must keep in the vanguard in regard to preparation of personnel, student affiliation, practice fields, concurrent staff education! I am almost ready to say that the whole future of public health nursing depends on whether the preparation of public health nurses is satisfactory. Over and over again we hear, "What preparation does the Education Committee of the N.O.P.H.N. recommend for this job,"—or that? Guess work will not do. We must make statements based on facts. We must have the staff to collect the facts and interpret them.

And not the smallest group needing us sorely on this question of educational preparation is that of the school nurses. It has been a bitter disappointment to all of us on the N.O.P.H.N. staff that so far our budget will not stretch to include another staff member who can devote the major part of her time to school nursing problems.

4. This brings me logically to a need which, like education, leads to standard-making and is a part of the backbone of N.O.P.H.N. service; namely, our statistical studies and research. Oh, for ten thousand *new* dollars just for this purpose! Think of how we could help you to make valuable studies if we had field service to give from our statistical department. Think of all the uncorrelated facts now lying dormant in your files and ours. Not a day passes but someone says, "We need a study of this"—or that. Uniform records and statistics are a dream that we won't realize until we can give more help to you in the field. We need more correlation of the data in the records of health departments and private agencies. We want to give you institutes on records. We want—well! Let's just remember this: That in the far days when FERA and WPA are forgotten, even beyond the time when you and I will be making speeches, *the N.O.P.H.N. studies will be in use.*

5. There are also untilled fields of service.

a. First is the challenge of industrial nursing, a public health job of the first importance if carried on properly, just a finger-wrapping job if it is not. This would seem to be a moment, with the recovery of business, when the N.O.P.H.N. can contribute to developing industrial nursing as a public health job. Here again a specially prepared nurse is needed on our staff.
b. There is the problem of nursing service to the middle-class group, and group plans of payment. If three cents a day pays for hospital care, and is such a success, why not two cents a day for home nursing service. What is the N.O.P.H.N. doing to be ready for health insurance if and when it comes?
c. How are we going to meet the demands of the students wanting ex-

perience in public health nursing, when the new curriculum is adopted? What shall be the duties of the public-health-nurse member of the school of nursing faculty? How is the N.O.P.H.N. going to assist you in finding practice fields for this group without undue exploitation of patients?

d. What constructive plans can we at the N.O.P.H.N. make with the new regional supervisors of the United States Public Health Service and the Children's Bureau? What working relationships can be developed that will save you from an overdose of national visitors? Will you, our members, want us to turn over some of our present program to them, releasing us for other activities?

New plans, new times, new faces! The N.O.P.H.N. has got to be on the job—in the vanguard of progress and not in the rear.

6. Last, but far from least, through the years we have said, "We believe in the partnership of citizens and professionals." Your experience shows, as does ours, that public health nursing will rise no higher than the understanding and support of its consumers. Therefore, we have consciously worked together in this partnership for twenty-five years, six of which have been with a definitely planned program through the work of a special N.O.P.H.N. staff member. We have gradually seen state after state, city after city, organize lay groups. Much of their inspiration must start from the N.O.P.H.N. Have we helped nurses enough in this? Are we helping you, our lay members, enough?

Isn't this a period, more than any other, when the development of new services, official in character, makes it necessary for our lay members to keep in touch with us? What if funds for official programs fail at the end of a few years and no citizens' committees stand ready to appeal to the community for continued support? I am perfectly sure that the permanency of public health nursing service is in direct ratio to the breadth of citizen understanding of its purpose and work. If we are to capitalize on the promising years just ahead, we must have citizen participation and knowledge of our work. Please help the N.O.P.H.N. to help you in this. If my report carried no other message, I would like you to remember this, that the future of public health nursing rests on the partnership between the nurse and the non-professional. We must devote major emphasis to this in the coming years.

I am a member of the N.O.P.H.N. and I would like to see us do these things. Only the unescapable dollar sign holds us back. It has held us back before but never, I truly believe, when it was so vitally and crucially important to everyone of us to have an active, functioning, progressive, national body to represent public health nursing. If the N.O.P.H.N. fails us now——! Dollars we must have. They can come from five sources, three of which you can influence profoundly; can, in fact, be totally responsible for if you will—and care enough.

These sources which you control are memberships—individual, agency, and life. We need 10,000 individual members in 1937 instead of 7500. Most of this increase should be among lay members. It is a commentary on our partnership that only ten per cent of our members are non-nurse members. What kind of a partnership is that? It has been said that three dollars is too trivial a sum to ask of lay people. Very well, let's ask for a contributing membership and secure larger amounts of money. I believe that if every nurse in every agency which is working with a board or committee presented the need of the N.O.P.H.N.'s program to her group, she could secure individual memberships from at least one third of that group. If the committee represents a scattered, rather straitened county service, it may be possible at least to raise the amount necessary for flat corporate membership dues among the members.

I believe that dozens of school, county, and city nursing staffs, and many more private agency staffs would be on the Honor Roll of 100 per cent nurse members if they stopped to think

what the support of their national organization means at this time.

I believe every present member could get one more member, nurse or lay, if she would.

I believe private agencies could secure the balance of their full one per cent national dues if the executive director and the president showed the board what is happening in public health nursing today and what the N.O.P.H.N. is trying to do. Community chests do not think our national dues excessive. The responsibility for corporate dues, therefore, rests with the board.

We want to count on 25 new life members for 1937 to celebrate our twenty-five years of service. (It is easy to become a life member on monthly instalments!)

In the meantime, of course, the Finance and Ways and Means Committees are concerning themselves with possibilities of help from other sources of income. And, as always, the N.O.P.H.N. office is doing its best to save us money by careful administrative methods, and the staff to earn money through special field service. But our figures show that the bulk of N.O.P.H.N. support, the money that will decide whether we step into a place of national influence or just sit by and watch the procession pass us, will come from interested individuals.*

How interested are you? I am not hesitant, as you see, to place this burden on you, our members. You want us to go forward; you want us to employ the best personnel as leaders; you want us to make your mark on the events of our time. Give us the wherewithal, and I can promise you that we will make that progress. As the Silver Jubilee year of the N.O.P.H.N. draws near, every one of you will be given a chance to see that your state joins in giving the N.O.P.H.N. the financial assurance that twenty-five years of work are not to be lost now, but are rather to mature into a stable, strong national service to public health nursing which will fill its rightful and needed place in our life.

*For figures see *Listening In*, published for the members of the N.O.P.H.N., Vol. V, No. 3, June 1936. Page 4.

Dear N.O.P.H.N. Members:

If I were to wait until October 1 when our membership year really ends and told you then that we had fallen short by 46 memberships of our 8000 goal for 1936, wouldn't most of you say, "Why in the world weren't we told earlier so that we could have done something about it?" But, you see, I didn't wait, so what are you going to do? Just 46 more members and we reach that 8000—the very largest enrollment the N.O.P.H.N. has ever had.

Now please don't each of you say to yourselves, "Oh, only 46. Well, they'll get those without my help." On page 625 you will find a special award announcement and an application blank for the member we are counting on you to secure. Wouldn't the offer of an N.O.P.H.N. pin tempt you if you were not already a member?

Listen for the shout of joy from the N.O.P.H.N. office the minute that eight thousandth nurse joins.

Sincerely yours,

DOROTHY DEMING,
General Director.

Report of N.O.P.H.N. Sections

1934-1936

SINCE reports of the activities of the three sections of the N.O.P.H.N. for the period 1934-1936 as presented at the Biennial Convention appeared in the June 1936 issue of *Listening In*, we are publishing only a brief résumé of the program and business meetings of these sections at the Biennial, together with the officers elected for the coming biennial period.

BOARD AND COMMITTEE MEMBERS' SECTION

Board and committee members from ten states (California, Iowa, Illinois, Indiana, Kentucky, Massachusetts, Nebraska, New York, Texas, and Utah) attended the Biennial Convention. A delightful tea given by the Visiting Nurse Association of Pasadena made the lay members feel welcome.

That part of the program especially planned for lay members included a round table discussion on board problems, a joint meeting with the public health nurses on the educational value of records, and the luncheon-business meeting of the Board and Committee Members' Section. The various joint sessions were of great interest, as were also many of the regular N.O.P.H.N. sessions, in some of which lay members participated.

At the Section business meeting it was unanimously voted to adopt the proposed revision of the rules for the Section. This revision increases the number of directors of the Section from seven to twelve, and specifies that two thirds of this number shall be lay members and one third shall be nurses to act as counselors. Therefore, four lay directors and one nurse director must be appointed.

EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

Chairman—Mrs. G. d'Andelot Belin, Waverly, Pa.
Vice-Chairman—Mrs. Frederick S. Dellenbaugh, Jr., Boston, Mass.
Lay Directors—Mrs. Gammell Cross, Providence, R. I.; Mrs. Clyde Cummings, Greeley, Col.; Mrs. R. Livingston Ireland, Jr., Cleveland, Ohio; Mrs. S. Emlen Stokes, Moorestown, N. J.
Nurse Directors—Edna L. Hamilton, R.N., Detroit, Mich.; Ruth Mettinger, R.N., Jacksonville, Fla., Eva S. Waldron, Springfield, Mass.

INDUSTRIAL NURSING SECTION

An interested group of nurses attended the morning round table for industrial nurses and the luncheon business meeting of the Industrial Nursing Section held on Wednesday, June 24, at the Biennial Convention. About forty nurses were present at one or both sessions.

The program for the morning round table included "The Industrial Nurse as a Health Teacher in the Small Industry," "The Industrial Nurse—Her Qualifications from the Point of View of the Physician in Industry," and "Eye Health in Relation to Industry." The first two papers appear in this issue of the magazine, and the last will appear in a later issue. The problems around which the discussion at the luncheon meeting centered were the lack of established standards for industrial nursing and the isolation of industrial nurses. As a result of this discussion the following action was taken:

1. A motion was passed requesting the N.O.P.H.N. to consider the addition of an experienced industrial nurse to its headquarters staff to act as a general advisor to the staff, committees, and field on the public health nursing aspects of the industrial nurse's job in relation to plant and community.

2. A motion was passed asking the N.O.P.H.N. to urge its state branches to

secure industrial nurses as members, and to form state industrial nurses' sections where there are enough industrial nurses to justify such action.

EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

Chairman—Hortense E. Gruber, R.N., New York, N. Y.
Vice-Chairman—Joan Johnson, R.N., Milwaukee, Wis.
New Nurse Directors—Mrs. Mary Elderkin Marsh, R.N., New York, N. Y.; Mrs. Kathryn M. Page, R.N., San Francisco, Calif.; Julia Weder, R.N., Egypt, Pa.
New Non-Nurse Director—W. E. Mack, Niagara Falls, N. Y.
Nurse Directors holding over from last Biennial—Nettie Amundsen, R.N., Milwaukee, Wis.; Mrs. Helen J. MacRae, R.N., Providence, R. I.
Non-Nurse Directors holding over from last Biennial—W. H. Cameron, Chicago, Ill.; Mrs. Austin T. Levy, Harrisville, R. I.; William A. Sawyer, M.D., Rochester, N. Y.
Honorary Life Member—Mrs. Marion T. Brockway, R.N., New York, N. Y.

SCHOOL NURSING SECTION

Two round tables on school nursing were held during the convention. The programs of both sessions were very interesting and well attended.

A high light of the section's activities at the convention was the school nurses' luncheon and business meeting held on June 24, at which there were 185 nurses. Eunice LaMona, Supervisor of School Nurses, Los Angeles Public Schools, welcomed the school nurses to Los Angeles with a greeting in verse.

A short, inspirational talk on the value of N.O.P.H.N. membership to school nurses was given by Leah Blaisdell, Educational Supervisor, New York State Department of Health, at the request of the Education Committee of the School Nursing Section. Because school nurses are called upon to make a real contribution as specialists in a field in which there are many new developments, Miss Blaisdell said it is essential that they get together through the N.O.P.H.N. for national guidance and leadership. She stressed the importance of having one person on the N.O.P.H.N. staff to give this leadership and pointed out that such a person can be provided only if school nurses demand it, support it and get behind it. She appealed to the nurses present to secure the 150 additional members needed by the N.O.P.H.N. to reach its goal of 8000 members in 1936, and many of the nurses present pledged themselves to secure one or two new members for 1936 and 1937.

EXECUTIVE COMMITTEE FOR THE NEXT BIENNIAL PERIOD

Chairman—Lula P. Dilworth, R.N., Trenton, N. J.
Vice-Chairman—Ella E. McNeil, R.N., New York, N. Y.
New Nurse Directors—Anna Heisler, R.N., Washington D. C.; Dorothy E. Wright, R.N., San Diego, Calif.
New Non-Nurse Director—Anne Whitney, Washington, D. C.
Nurse Directors holding over from last Biennial—Mrs. Ruth Carroll, R.N., Houston, Texas; Mellie Palmer, R.N., Malden, Mass.
Non-Nurse Director holding over from last Biennial—James F. Rogers, M.D., Washington, D. C.

CONCERNING THE STATE OF OUR FINANCES

As a detailed statement of N.O.P.H.N. income and expense for 1935 appears on page 183 of the March 1936 issue of PUBLIC HEALTH NURSING and the report of the Finance Committee was published in the June 1936 issue of *Listening In*, we would like to refer our members to these two sources for information regarding our present financial position.

Biennial Report of Joint Vocational Service, Inc.*

1934-36

TEN years ago at this time the membership of the National Organization for Public Health Nursing voted to unite its vocational effort with that of the American Association of Social Workers, and on January 1, 1927, the Joint Vocational Service for Social Workers and Public Health Nurses, Inc., came into existence. Eight additional nationally functioning social and health agencies cast their vocational lot with us at that time, and to these, six others have been added through the years. If the limits of this report permitted, a "surview" (to borrow a word from Coleridge) of this decade of activity would, it is believed, convince you of the effectiveness of this type of organization, where the common purpose of all participants is the safeguarding of standards of worker and work as related to community health and welfare. The happiest of relationships have existed.

The Joint Vocational Service has long since emerged from the stages of initial organization and experiment, an experiment which bears the mark of being a noble one. History has been made in the pooling of two different, yet closely related vocational interests and methods, with a scrapping of the less effective techniques and retention of the best, insofar as lay within the scope of our financial possibilities. Any professional employment and vocational service is a barometer of economic conditions and is quick to get reactions pertaining to social readjustments. As has been true in the case of many organizations which J.V.S. has served, the last few years have for J.V.S. been fraught with budgetary difficulties, increased volume of work, decrease in staff and adaptations necessary to meet emergency situations as adequately as possible. That the ship has been kept afloat—even though not always at even keel—we believe is largely due to your demonstrated confidence and coöperation and your recognition that J.V.S. is not a thing apart, but that it is in every sense *your own* vocational service, through the N.O.P.H.N.'s part in it.

In an account of our stewardship for the biennium 1934-36, we revert to our last report to you when the first signs of improvement in the employment situation were mentioned as appearing upon the horizon. We are at this time able to say that the past two years show a greater volume of work than any similar period in our history, that numbers of new jobs reported in your special field have greatly increased, that qualifications of candidates have improved and the percentage of placements has been higher. Statistics cannot give you

COMPARATIVE STATISTICS OF VOCATIONAL SERVICE IN PUBLIC HEALTH NURSING

	Biennium Jan. 1932-Jan. 1934	Biennium Jan. 1934-Jan. 1936	
Positions handled	752	1137	Increase 385—52.7%
New positions	661	1006	Increase 345—52.1%
Registrants**	2408	2523	Increase 115— 4.3%
Interviews and conferences	3777	5391	Increase 1614—42.7%
Letters (outgoing)	14,791	19,345	Increase 4554—30%
Referrals	4330	6624	Increase 2294—53%
Placements and assisted placements	426	527	Increase 101—23.7%

*Presented at the N.O.P.H.N. opening Business Meeting at the Biennial Convention, Los Angeles, California, June 22, 1936.

**A conscious effort was made to reduce the intake to the best qualified applicants.

a true picture of all of our activities, but they are presented as the only device for comparative measurement.

INTERPRETATION OF FIGURES

In casting the searchlight upon these figures, the following facts should be borne in mind as aids in interpretation:

1. The J.V.S. has made a consistent effort to reduce the intake of registrants to those who have claim on the field through special qualifications. It is significant that 81 per cent of the registrants in 1935 had completed or partially completed public health nursing courses as compared with 71 per cent in 1932.

2. It has not limited the counseling aspect of its service and no figures are produced on this aspect, but we are aware of its vast increase.

3. Many positions worked on (sometimes for weeks or months) were cancelled or dropped, usually due to inability of employers to finance their plans. Of 1398 positions closed in 1934 and 1935, 202 were thus closed, leaving a total of 996 bona-fide positions. In the case of 53 per cent of these, J.V.S. effected a placement.

4. There were 20 per cent more positions reported in 1935 than in 1934, and so far in 1936 this same rate of increase over 1935 is continuing.

Placements resulting from records sent out to employers upon request of candidates constitute assisted placements only when we have the job registered. This service including building and rebuilding of records is extremely expensive, yet it is given without charge.

6. Employers are more discriminating than ever before as to qualifications of candidates. Generally speaking, potentialities of candidates play only a small part in their chance for consideration. Not only are specialized preparation and highest personal qualifications now demanded, in addition to special experience, but usually the employer wants that experience to include a period of proved ability in the specific type of opportunity he has open. As demand and supply become equalized we predict that this situation will change.

7. The demand for candidates with a claim on residence still constitutes a placement problem, but we see some improvement toward greater flexibility in this as a stipulated qualification.

8. The staff of J.V.S., both clerical and professional, was reduced for budgetary reasons. The position of second vocational secretary in public health nursing was temporarily dropped in September 1932, except for vacation relief. It was restored temporarily April 1, 1936, and we hope it may continue permanently. The generosity of N.O.P.H.N. in adding $1000 to its grant for 1936 has helped to make this possible.

9. The decreased staff and increased demand have resulted in unavoidable and regrettable delays in correspondence and in referrals of candidates, and a limitation of field contacts.

10. The volume of work in the social work field as related to that in public health nursing continues at an approximate ratio of 2 to 1.

11. The inadequate budget has curtailed publicity, and also research based on the wealth of material of national vocational interest in our files.

12. Tremendous pressure has come through service to the various governmental projects, without payment for service from the agencies served, and often not from candidates when placements are effected. J.V.S. made no placement charge for work relief appointments, and cannot charge when placement eventually results from certification from civil service lists—although we may be responsible for establishing all preliminary contacts, furnishing records, etc. Yet withal this is a service we have been happy to render with the protection of the field and real helpfulness to workers in view.

13. Placements are more difficult to make when effort is duplicated or less centralized. We have been aware of an increase of confusion. Some plan of better clearance and centralization is indicated. A committee of J.V.S. nurse board members has studied this and made its report to the Board of Directors of the N.O.P.H.N.

A budget of $52,800 has been approved for 1936. It is estimated that

the cost for the public health nursing aspect of the work will be $18,400 in 1936. The 1936 budget as a whole (which, although not considered adequate, was as large as our Board felt able to pass) indicates that new money must be found. J.V.S. has always made an effort to divide its cost of maintenance between candidate and employer. Social work organizations make service payment to J.V.S. for the handling of positions or give direct subscriptions. The N.O.P.H.N. pays an annual sum outright for service to its corporate members.

Fees from candidates for placement increased from $10,747 in 1932 to $17,516 in 1934 and dropped to $14,600 in 1935. Foundation grants have rounded out the budget, although there have been current losses and additions in these grants. We are particularly fortunate in having a strong finance committee under able chairmanship. While some new money has been secured through new grants in 1936, there is still a need for continued vigilance.

Other developments occurring during the past biennium which we assume to be of interest to N.O.P.H.N. members are:

1. There has been an addition of three organizations to J.V.S. board representation, namely:

American Association of Schools of Social Work
American Public Welfare Association
Community Chests and Councils.

2. There has been an addition of members at large to our board. Two prominent laymen are at present serving.

3. Closer working relationships have been established with the:

FINANCIAL REPORT OF JOINT VOCATIONAL SERVICE

	1932	1933	1934	1935
Receipts	$33,134.33	$38,068.06	$37,476.66	$43,480.66
Disbursements	33,149.58	38,262.27	36,676.63	42,680.63

National Tuberculosis Association
National Committee for Mental Hygiene
Family Welfare Association of America.

These organizations have served on our board since the establishment of J.V.S.

4. A very desirable plan of coöperation has been established with the National Association of Colored Graduate Nurses.

5. A case conference made up of social workers and public health nurses has been appointed and is now at work on a study of reference writing and reference evaluation with a view to recommendations for general improvement.

6. We have more and more relied upon and made use of our affiliation with the N.O.P.H.N., whose staff members serve for us in promotion and interpretation in the field and are in continuous consultation with us. Through this affiliation we keep in close touch with changes and developments in the public health nursing field as a whole.

The N.O.P.H.N. records are a constant source of help to us. It is inconceivable that any professional placement and counseling agency could be effective without this close relationship and proximity to its parent organization.

In conclusion, it seems well to restate that the common aim of you as members of the N.O.P.H.N. and us in whom you have entrusted responsibility is to build up steadily a service that will continue to make its imprint by the merits of its work.

ANNA L. TITTMAN, R.N.,
Vocational Secretary.

THE AMERICAN JOURNAL OF NURSING FOR SEPTEMBER

State Advisory Nurses Discuss Problems

THIRTY-NINE persons attended the dinner meeting of advisory nurses in state departments of health, held on June 23, 1936, at the Biennial Convention in Los Angeles, California. Not only were twenty-four states and the Territory of Hawaii represented, but guests from several national organizations were present. These included nursing representatives from the U. S. Public Health Service, the Children's Bureau of the U. S. Department of Labor, the Office of Indian Affairs, the Metropolitan Life Insurance Company, the John Hancock Mutual Life Insurance Company, and the American Red Cross, as well as members of the N.O.P.H.N. staff. Olivia T. Peterson, Superintendent of Public Health Nursing in the Division of Child Hygiene of the Minnesota State Department of Health, acted as chairman of the very interesting session. Various problems and issues of vital importance to nursing services in state health departments were discussed.

Personnel practices

Since health departments are especially interested in the study of personnel practices in official agencies now being conducted by the N.O.P.H.N., Marian G. Randall—who has been loaned to the N.O.P.H.N. by the Milbank Memorial Fund for a period of six months to work on this study—outlined briefly the plans for the study and reported on the progress being made.

Functions of the N.O.P.H.N.

This large gathering of state advisory nurses gave Sophie C. Nelson, chairman of the Committee to Study the Functions of the N.O.P.H.N., an excellent opportunity to explain the work of this committee. She asked each nurse in attendance to send in to the N.O.P.H.N. some expression of her own opinion and that of her department of health in regard to what they expect from the N.O.P.H.N., and what they think should be its functions in view of the present trends and developments in public health nursing and particularly in view of the federal health program.

Advisory service to industrial nurses

Ruth Houlton, secretary of the Industrial Nurses' Section of the N.O.P.H.N., brought to the meeting a question frequently asked of the N.O.P.H.N. by industrial nurses: What consultation service and other assistance may be secured from their state health departments? In the discussion of this subject, it was suggested that those state health departments which have industrial hygiene divisions are usually prepared to give advisory assistance to industrial nurses. It was reported that New York State is ready to give industrial nurses the benefit of its educational program; and that Indiana makes a few industrial nurse placements and will give advisory service on request.

Lay participation

A stimulating discussion of the importance of lay participation in official health programs was opened by Evelyn K. Davis, secretary of the Board and Committee Members' Section of the N.O.P.H.N. She said that the members of this Section feel that citizens must become better informed if public health programs developed under the provisions of the Social Security Act are to be permanent, and that lay groups should be formed in connection with official health agencies in cities and counties.

Dr. Estella Ford Warner of the U. S. Public Health Service was emphatic in her agreement with this opinion, stating that "The rise or fall of the whole movement depends on whether there is intelligent participation by the lay group. Many people know nothing about the aims and purposes of a community health service, yet the continuance of the work depends upon appropriations. Interested citizens must be shown that on them falls the responsibility through their county and state

organizations of getting the necessary appropriations, if work under the Social Security Act is to be permanent. Public health nurses should appreciate the use of lay groups in analyzing and interpreting the needs of the community as well as in giving volunteer assistance. I am convinced we give them too much advice and not enough education. We 'tell' them but don't give them anything to do."

Lay participation in official programs is an established fact in some states and is being developed in others. For example, Florida has public health nursing committees in almost every county, although members of these committees seem to become less interested as county health departments are formed. It was reported that state councils or citizens' committees exist in connection with the health departments in Iowa, Washington, Idaho, New York and Minnesota.

The possibility of a council or committee which is concerned with both health and welfare activities in rural counties was discussed, since the same people usually serve in both capacities in such counties. Idaho, Washington, Texas, and other states are considering such joint committees. The suggestion was made that it might be possible to set up organizations for rural areas analogous to councils of social agencies in cities. These in turn would have subcommittees on various phases of the work. All agreed that the interest of lay committees in private agencies is maintained largely because they must "find the money" and assist in administration of the program, and that when these functions are withdrawn, other activities must be substituted.

Standing orders

The question of standing orders for public health nurses was discussed. Miss Randall offered to collect standing orders from the various states in connection with the study of personnel practices in official agencies, so that these can be made available from the N.O.P.H.N. office in loan folders. Some of the states which are known to have such standing orders are New York, New Jersey and Minnesota.

One state reported the difficult problem of having only one health officer available for 20,000 square miles of territory. While some counties in this state also have the services of a part-time county health officer, large areas have no physician, and often the nurse is the only one who visits an ill person. When this is true, the question arises as to whether she is not practicing medicine if she gives any assistance. It was the consensus of opinion of those present at the meeting that in such situations standing orders would be of great assistance. These orders may be so worded that the nurse, although making no diagnosis, may give treatment or advice in the case of certain definite symptoms. For example, for a temperature she may give the patient a sponge bath, advise rest in bed, arrange for the isolation of a patient, or advise exclusion from school. However, although standing orders are of definite value and help, the situation must be presented repeatedly to the organized medical group as being fundamentally their own problem. Such a presentation of the problem has sometimes resulted in the addition of doctors to the health department staff.

NOMINATING COMMITTEE FOR 1938

The three members of the Nominating Committee which were elected by the N.O.P.H.N. membership at the Biennial Convention are as follows:

Laura A. Draper, R.N., Minneapolis, Minn., *Chairman*
Ira V. Hiscock, New Haven, Conn.
Winifred Rand, R.N., Detroit, Mich.

The remaining two members of the Committee will be appointed later by the N.O.P.H.N. Board of Directors.

What Is Your State Doing?

A CHALLENGE for 1937 was offered by the report of the activities of the state organizations for public health nursing and public health nursing sections, made at the Biennial Convention in Los Angeles, California. These reports were presented at the dinner meeting for S.O.P.H.N. presidents and section chairmen on June 25, 1936. Although presidents and chairmen could not all be present, fourteen of the eighteen S.O.P.H.N.'s and thirteen of the twenty-eight public health nursing sections sent representatives. These, together with members of the N.O.P.H.N. Organization Committee, representatives from the U. S. Public Health Service, Children's Bureau, N.O.P.H.N. staff and other national organizations, made up a group of some fifty persons.

The discussion centered on the various activities of the state public health nursing organizations with special emphasis on membership, education, lay participation, and coöperation with state departments of health.

Membership

Public health nursing sections have been working to secure 100 per cent membership of public health nurses employed in the state. It was reported that Maine doubled its membership last year. State organizations for public health nursing want interested lay persons as well as public health nurses for members.

Each S.O.P.H.N. has its N.O.P.H.N. membership representative. Oregon reported that over ninety per cent of the public health nurses in the state are members of the state organization for public health nursing; New Jersey reported that seventy per cent of its nurses are members.

Education

Some public health nursing sections limit educational activities to programs at the time of state meetings. Other sections, and all of the state branches, emphasized regional and state conferences or institutes on various topics. In many cases these institutes are planned to include lay persons, and a number of states are planning to include institutional nurses and members of hospital boards in certain conferences. Some state groups have selected the health sections of the Social Security Act for study this year. Many state public health nursing groups are concerned with helping to give to student nurses a public health point of view, and have plans for assisting graduates to attend public health nursing courses by means of loan funds.

Lay participation

The importance of securing the membership and participation of interested lay persons was mentioned by every state branch. This was considered particularly significant at present in view of the development of public health nursing under official agencies.

Coöperation with state departments of health

Many state groups reported that they are used in an advisory capacity by the state departments of health, especially in relation to the developments now made possible through federal aid. One state branch reported that it had nominated the nurse who was appointed as chief consultant in a child hygiene division. Several S.O.P.H.N.'s are represented on advisory committees to health departments or nursing divisions.

Other activities

One state organization for public health nursing reported an experiment in facilitating good medical-nursing relationships. Public health nurses were advised to keep a record of all patients referred by public health nurses for medical advice who probably would not have consulted a physician otherwise. The results obtained from this plan were encouraging. Another group told of the standing orders worked out with its state medical society.

One S.O.P.H.N. told of a demonstra-

tion of a county board meeting given at its annual convention. Another described its traveling library on public health subjects.

Functions of the N.O.P.H.N.

In addition to the interest in activities for the coming year stimulated by these reports, several very concrete suggestions were made. Sophie C. Nelson, as chairman of the N.O.P.H.N. Committee to Study the Functions of the N.O.P.H.N., asked state public health nursing groups to secure and send to N.O.P.H.N. headquarters during the summer or early fall opinions, both individual and group, as to what the future functions and services of the N.O.P.H.N. should be in view of present-day developments. Could not this be a topic for the first fall board meeting? Perhaps a committee might be appointed to secure individual opinions and to work out recommendations. In this connection, one suggestion was made by several persons during the convention—that the N.O.P.H.N. should function more fully through its branches, and also perhaps, although less directly, through state public health nursing sections. The N.O.P.H.N. staff consider this a most constructive suggestion. So—prepare to be used!

Industrial nursing

Another specific activity, urged by the Industrial Nursing Section of the N.O.P.H.N., was that state branches and public health nursing sections search out industrial nurses and encourage them to join the state public health nursing group and the N.O.P.H.N. In order to interest them in becoming members, it will be necessary to plan programs of value to them, at hours when it is possible for them to attend.

Is not this a suggestion which every state public health nursing group will wish to follow this year when planning programs?

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The Industrial Nurse *

Her Qualifications from the Point of View of the Physician in Industry

By PHILIP STEPHENS, M.D.

Medical Director, Southern California Telephone Company, Los Angeles, California

THE subject for consideration is: What are the qualifications of a good industrial nurse? Like the practice of medicine, the profession of nursing has become more and more specialized. In addition to the standard course of instruction given in all good schools of nursing, a nurse desiring to qualify for specialized work is required to take additional training or to acquire, through experience, other knowledge which will better qualify her for the position to be filled.

There are certain fundamental requirements for a successful nurse: for example, poise, personality, intelligence, loyalty, honesty, and physical endurance. These requirements she must measure up to and without them she should not be graduated from a school of nursing. In addition, there are special qualifications which are necessary if a nurse is preparing to enter upon an industrial career.

The industrial field also has a number of branches, which require some variation in the selection and training of those who do industrial nursing. While there may be other branches than those included in the following classifications, I believe that, in general, we may consider them under these headings:

1. The office industrial nurse.
2. The plant nurse
3. The plant nurse, in large and more or less hazardous manufacturing activities
4. The visiting industrial nurse, in corporations having extensive social service activities

There are some important qualifications which are sought for in any type of industrial nursing, and which are necessary for a smooth-running, well coördinated program. My ideas about these qualifications are, in all probability, somewhat arbitrary. However, they have been developed over a period of many years of experience in training inexperienced personnel or selecting previously trained and experienced workers and adapting them to the needs of this work.

PERSONAL QUALIFICATIONS

An industrial nurse should be mature in mind if not actually in years. She should be physically sound and able to endure hardships under trying circumstances. She should have a pleasant, and at the same time a firm personality. Her social relationships and her professional relationships should be well separated by a line of significant demarcation. However, she should strive to deserve the respect and regard of those with whom she mingles daily in the course of her professional duties.

The nurse should either know or be capable of acquiring a knowledge of the complex and intricate aspects of the industry in which she is an integral part of the personnel. She should familiarize herself with the entire personnel from the general manager to the watchman and in so doing develop that rare quality of being able to assist in the promotion of friendly relations between the employee and the employer, a consideration of paramount and vital importance in all corporate organizations of today.

The industrial nurse should also learn about the attitude of labor toward working conditions and should be able to analyze and evaluate circumstances and conditions as they develop or occur in the course of her day-to-day duties. She should be on the alert to observe what is

*Presented before the N.O.P.H.N. Round Table for Industrial Nurses, Biennial Convention, Los Angeles, California, June 24, 1936.

going on about her but talk little or not at all unless she or her medical department is directly concerned.

She should be loyal to the workers and also to her employers; and from her point of vantage in the organization she should be able to quietly yet impartially see and assist in the handling of the many daily problems—problems not always having to do with bandages and antiseptics.

The scope and value of her service will be broadened if she knows how to use the typewriter and can take stenographic notes. A good knowledge of anatomy and the proper use of medical terminology will greatly add to her efficiency and will promote smoothness and effectiveness in her day-to-day production on the job.

SPECIFIC ABILITIES

While we do not expect the industrial nurse to be a first aid surgeon, we do expect her to have an understanding of the principles and practices of modern surgery. She should know thoroughly the ordinary standard American Red Cross first aid practices. Although her training in surgical technique should, of necessity, extend far beyond the scope of Red Cross practices, yet as a beginning they are invaluable. Proper surgical technique is of paramount importance, but it cannot be carried out without a systematic orderliness and neatness—so quick to be noticed and approved by all who come in contact with the nurse.

Gentleness and sympathetic consideration are two of the qualities expected of all nurses at all times, but I especially refer to them here because the average worker with whom the nurse comes in contact has a feeling—and I know not why—that we in the health service are always in a hurry, that this is characteristic of our daily routine, and that we are going to be rough and hurried in our treatment of the patient. The industrial nurse should have the faculty of demonstrating by quietly spoken words, and then by action, that she can and will be gentle and in so doing dispel this prejudice, thereby creating confidence in the health service.

Most of the personal qualities which I have mentioned might be crystalized into the one word, tactfulness—but this word as applied to an industrial nurse needs much amplification.

The keeping of accurate records is highly important. The accurate, pertinent history of events written down at the time of an accident go far toward the prevention of controversial litigation which may arise in the course of the subsequent care and disposal of an injury case, and such a record materially assists the doctor in his work and results. Many pertinent incidents are related at the time of the first examination in an accident case which, if promptly and accurately recorded, clear up problems which develop later due to the faulty memory of the patient. I do not mean that the nurse should be entirely responsible for the promptness and accuracy of injury reports, but she should assume a large part of it.

In considering the qualifications of the industrial nurse in the office of an average business organization, we might say that she should possess all of the qualities mentioned in the foregoing, beside having a special aptitude for clerical duties. She can be of great assistance also if she acquires a knowledge of laboratory technique. The average office doing some minor surgery will usually be equipped with a small modern x-ray laboratory; and the nurse who is able to make x-ray exposures of the extremities and develop them will be of particular assistance to the surgeon and will thus relieve him of the necessity of sending out these semi-emergency injury cases to x-ray laboratories or nearby hospitals.

IN HAZARDOUS INDUSTRIES

The nurse expected to function in a plant where hazardous work is performed, and where major injuries occur, must be especially fitted to cope with disasters. Usually she is not alone, but acts as an assistant to a plant physician who is continuously on duty or at least within ready call. In these positions where there is the necessity for the nurse to assume considerable responsibility in giving the immediate first aid so often

necessary in major accidents, she should be alert, capable, and of forceful character. She should not only be able to handle her surgical and first aid problems, but also have a sufficiently dominating personality so that she can handle excitable, and very often, hysterical fellow workmen, who are inclined to get out of hand at these times of emotional stress and strain.

AS PERSONNEL ASSISTANT

The industrial nurse who also acts as a personnel assistant must have special training for this work, as there are many sociological problems continually presenting themselves. In addition to a sound understanding of human relationships, it is desirable that she should be especially trained along social service lines or at least should understand the fundamentals of that service, which will help her with the many problems arising among the working personnel.

In summarizing our remarks, we might say that a good industrial nurse should be fundamentally a good nurse with a sense of obligation to her fellow man. In addition to this, she should be mature mentally, strong physically, broad and tolerant in her views of life, dignified and yet friendly, loyal to her profession, and willing, if need be, to improve and perfect herself in various other closely related branches in order to adapt herself to the changing requirements of specialized work.

Inasmuch as the demand for industrial nurses is constantly increasing, and since forward-looking employers are wanting carefully selected and well prepared nurses, I feel that our schools of nursing should take cognizance of this need and should meet it either by incorporating the teaching of the special requirements in their present nursing courses or by inaugurating special courses to cover the much needed additional requirements for successful industrial nursing.

NOTES FOR YOUR FALL CALENDAR

September 20-25—The 18th national convention of the American Legion meets in Cleveland, Ohio, on these dates. A gala round of entertainment is being planned for ex-service women, and a cordial invitation is extended to all ex-service nurses to attend the grand reunion and banquet scheduled for Monday evening, *September 21,* when old friendships will be renewed and the stirring days of the war period re-lived. Margaret Waller Lucal, commander of the Edith Work Ayres Post 402 of the hostess city, is chairman in charge of ex-service women's activities.

October 5-9—The National Safety Congress will meet in Atlantic City, New Jersey, on these dates. A session for industrial nurses will be held on Thursday morning, *October 8,* in Room 2 on the second floor of the Atlantic City Auditorium. This meeting is arranged in coöperation with the Industrial Nursing Section of the N.O.P.H.N. Industrial nurses may obtain the first edition of the Congress program by writing to N.O.P.H.N. Headquarters, 50 West 50th Street, New York, N. Y.

October 6, 7, 8, and 9—The examination for registration of nurses in Wisconsin will be held in Milwaukee and Ashland on these dates. Applications must be on file in the office of the Bureau of Nursing Education, State Board of Health, Madison, Wisconsin, not later than *September 15, 1936.*

October 11-16—The annual convention of the American Dietetic Association will be held at the Statler Hotel, Boston, Mass.

Successful Teamwork

*How the Private Public Health Nursing Agency May Work Better with the Individual Physician**

By HELEN LAMALLE, R.N.

Superintendent of Nursing, Pacific Coast Division of the Metropolitan Life Insurance Company, San Francisco, California

FOR the past fifty years visiting nurse associations have been giving nursing care to the sick, yet there are some physicians who do not know that these associations exist, and even more who do not know what they are doing. This was brought forcibly to my attention recently when I talked to the president of a county medical society. I was telling him something about the work of his local visiting nurse association and he remarked, "I think that is a fine idea. I hope you will have every success in your venture."

I looked at him in amazement and could not help remarking, "But, Doctor, this movement has been going on here for a number of years and in the country as a whole for the past half century."

FINDINGS OF N.O.P.H.N. SURVEY

My experience with this physician led me to investigate the relationships between public health nursing agencies in general and the individual physicians. In 1931-32 a committee of the N.O.P.H.N. made a field survey of public health nursing in 28 cities, towns, and counties in different parts of the country. Included in the survey were 57 official and non-official public health nursing agencies, of which 21 were privately administered. In summarizing the findings with regard to medical relationships, the committee reported that working relationships of non-official public health nursing agencies with physicians were much more direct than those of agencies administered by health departments or boards of education. The official agencies, of course, do far less bedside nursing than the privately administered agencies.

Of the 21 privately administered organizations, all of which offered bedside nursing service, the committee found that 76 per cent had definite working relationships with organized medical groups. Only 52 per cent had standing orders approved by such groups. As to the general attitude of the individual physicians, it was reported as friendly by 75 per cent of the agencies and as indifferent or apathetic in the other 25 per cent.

CRITERION OF RELATIONSHIPS

One criterion of the relationship between public health nursing organizations and the medical profession is the extent to which the individual practicing physicians call upon the nursing agencies for care of their patients. The survey covering the 21 privately administered public health nursing organizations brought out the following findings on this question:[1]

1. Five of the groups gave no figures on the extent to which local physicians used their services.
2. Six estimated that the "majority" or "many" physicians used their services.
3. One estimated that about one third used them.
4. Nine said that "few" physicians used them.

This survey was completed four years ago. In order to learn whether the situation has changed in these four years letters were written to a number of the large visiting nurse associations of the country, asking them for figures on the percentage of their cases reported by

*Presented before the N.O.P.H.N. Round Table on Relationships—Medical and Social at the Biennial Convention, Los Angeles, California, June 24, 1936.

physicians. The following percentages were forthcoming:

PERCENTAGE OF CASES REPORTED BY PHYSICIANS IN THIRTEEN VISITING NURSE ASSOCIATIONS IN THE UNITED STATES FOR 1935 OR LATEST AVAILABLE FIGURES

Agency	Per Cent
Baltimore Instructive Visiting Nurse Association	1.4
Seattle Visiting Nurse Service	1.5
Henry Street Visiting Nurse Service	2.8
Oakland Visiting Nurse Association	4.0
New Haven Visiting Nurse Association	4.1
San Francisco Visiting Nurse Association	5.0
Toledo District Nurse Association	5.1
Pittsburgh Public Health Nursing Association	6.0
Boston Community Health Association	7.0
Washington, D. C., Instructive Visiting Nurse Society	8.3
Chicago Visiting Nurse Association	13.0
Philadelphia Visiting Nurse Society	14.0
Detroit Visiting Nurse Association	20.0

In only three associations was the percentage of cases reported by physicians more than 10 per cent. In the other ten the percentage was less than 10 per cent, and in five of the associations the percentage was less than 5 per cent.

The Metropolitan Life Insurance Company has contracts with visiting nurse associations throughout the United States and Canada, and we were interested to know what their experience with local practicing physicians was. The Metropolitan nursing service is carried on according to a threefold plan: In many cities where a visiting nurse association has been established, the Company affiliates with this association and agrees to pay the cost of the visits made to our policyholders; in other cities the nursing is done by salaried nurses employed by the Company, or by individual part-time nurses.

The territory served by the Company in Canada and the United States is divided into ten main districts. Our records show that in these districts the following percentages of nursing cases were reported by physicians:

PERCENTAGE OF CASES REPORTED BY PHYSICIANS TO METROPOLITAN LIFE INSURANCE COMPANY NURSING SERVICE IN TERRITORIAL DISTRICTS OF THE COMPANY FOR 1935

Territorial Districts	Per cent
Pacific Coast	1
Metropolitan	2
Central	3
Southern	3
Great Lakes	4
Southwestern	4
Atlantic Coast	6
Great Eastern	6
Canada	11
New England	16
All Districts	6

You will observe that the average for all districts is 6 per cent. This may be somewhat lower than the actual per cent because some cases which were reported by physicians may have been included in the percentage reported by families. Such a situation would occur when the physician asks the family to call a public health nurse and the family transmits the call to the visiting nurse association. Even making allowance for a small proportion of physicians' calls given by the family, it is still appalling to find an organization which was established to coöperate with physicians, receiving such a small percentage of its cases at the instigation of physicians.

A recent study of Metropolitan Life Insurance Company mortality records revealed additional evidence of the lack of a close working relationship between the medical and nursing groups. Among all the deaths from pneumonia of policyholders who were entitled to nursing service furnished by the Company, 50 per cent were reported as having had no skilled nursing care. Pneumonia is one disease in which good care is highly important. Yet in the case of half of these patients, a nurse was not called in to give of her skill.

What is the reason for this apparent lack of coördination between the medical profession and the public health nursing group? The National Organization for Public Health Nursing studied this subject in 1933. The Organization sent out questionnaires to 160 representative public health nursing agencies in the United States, on the subject of medical relationships. The

replies received from the 132 organizations which answered the questionnaire indicated that public health nursing associations have not made a careful study of the most effective means of developing a cordial and mutually helpful relationship with medical groups.[2] The Organization suggests the main causes of this lack of coördination, and if we will face the facts honestly, we all know from our own experience in similar situations what these are:

1. Misunderstanding on the part of the physicians as to the function of the public health nurse—the work that she does and the orders under which she operates.
2. Apprehension of the physician that the nurses' visits may replace his own.
3. Lack of frequent conferences between attending physician and nurse on all individual cases, so that the physician may know what care is being given.
4. Occasional lapses in professional ethics by a few nurses—*e. g.*, not following meticulously the attending physician's orders.
5. Inclination of nurses to request free medical care or a transfer to the county hospital for patients who might possibly be able to pay.
6. Sponsorship of clinics by the nursing organization, without the consent and approval of the medical group.

It is easy to see how these misunderstandings occur. The public health nurse is imbued with the spirit of prevention of disease and the promotion of health from the community standpoint. The nurse's salary is paid whether she collects her fee or not. She is anxious that the patient get the best care possible and she may have sometimes been tempted to make suggestions to the family on the basis of her knowledge and experience with certain physicians. The physician on the other hand has a different point of view. He is as eager as the nurse to restore the patient to health and is anxious to give the best care possible. But the responsibility for the case rests with him and he does not want a nurse taking it out of his hands. He is commander-in-chief of the situation. He must be sure that his orders are not countermanded or ignored. He must have some assurance that the nurse's advice coincides with his own views. And he is right. His wishes are legitimate.

The N.O.P.H.N. has recognized this prerogative of the physician and has laid down specific instructions for public health nurses in its *Manual of Public Health Nursing*. Let me quote a few statements from the Manual. "All patients receiving nursing care must have medical supervision. The nurse is expected to communicate with the physician in attendance regarding each patient and must observe professional etiquette. . . . No treatments except as stated in standing orders should be given without a physician's order and these should be used only until it has been possible to communicate with the physician."[3] One of the first principles for public health nurses is to carry out the orders of the attending physician.

Where, then, is the missing link that breaks the desired connection between the physician and the public health nurse? It seems to me that it is the lack of getting across to the physician the fundamental principles on which public health nursing services are based. It is neglect to interpret ourselves to the medical profession so that they realize just what we stand for and what we *do*.

According to the best medical practice, the only effective way to cure a disease is to remove the cause of that disease. How shall we remove the cause of the disease that has attacked the relationships between the medical profession and the public health nursing associations? By beginning at the beginning and meticulously interpreting to physicians our aims and practices; by making this a continuous educational program; by seeing that our nurses adhere strictly to the highest ethics of the profession at all times; and by extending our services only with the approval and the coöperation of the local medical group.

In connection with my investigation, letters were written to a number of the large visiting nurse associations of the country which have been studying this problem and have worked out some system of their own for making the physicians aware of their program and for interesting them in making wider use of the nursing service. The things

which seem to stand out particularly as being most successful in building up satisfactory medical relationships are:

1. Continuous education of the medical group to the program and aims of the nursing organization.
2. Periodic approval of nurses' standing orders by the local medical society.
3. Appointment of a medical advisory committee which meets regularly and discusses nursing problems and procedures.
4. Frequent conferences between attending nurse and physician on nursing care for all individual cases.
5. Strict adherence to nursing ethics by all nurses.
6. Participation of the agency in clinics only on invitation or with approval of medical group.

None of these suggestions is new. You will find them all in the N.O.P.H.N. literature, but we are prone to start out with good intentions and then get so busy that we neglect these most important considerations.

These suggestions constitute interpreting ourselves to the medical profession. And let me emphasize here that interpreting ourselves is not a matter of merely talking to the president of the medical society and informing him of our aims and practices. It is a process of continuous education. It means bringing the subject up time after time, informing the profession of any changes in practices or procedures. It means having standing orders understood and approved, not once, but periodically, and meeting regularly with representatives of the medical group for discussion of ordinary and special problems. Mary Gardner, in her book *Public Health Nursing* says, "The best medical advisory committees, though they may not meet frequently, do meet regularly. For meetings that are called only in moments of distress, too little background is provided for wise decision."[4]

Some of the specific plans for satisfactory medical relationships outlined by individual visiting nurse organizations to whom we wrote, include the following. Seattle is planning to have a rotating medical advisory committee of nine men, with three new men appointed each year. This plan would eventually bring the entire medical society into active contact with the nursing organization. Brooklyn showed a film of the nursing work to the medical society. The organization advertises regularly for six months of the year in the local medical bulletin and sends a folder on the work of the organization to each physician. The Henry Street Settlement Visiting Nurse Service has a medical advisory committee made up of specialists from the various fields and a representative from each of the three county medical societies in the territory. New Haven has a medical advisory committee of five and also subcommittees of specialists—such as obstetricians and heart and lung specialists—to whom special questions are referred. The subcommittee's decisions are submitted to the general medical advisory committee for ratification. Detroit submits its standing orders to the county medical society for approval every year. It seeks the approval of the medical committee on all new plans and procedures. Pittsburgh has a medical advisory committee of six members, three of whom are appointed by the board of the association and three by the county medical society. San Francisco sends a "thank-you" note to physicians who are using the organization's services for the first time. It uses the medical group for staff education in the case of new projects.

All of these plans seem excellent suggestions for building up a closer coöperation between the medical and the public health nursing groups. Let us resolve to do something about this most important matter. We think we are too busy to spend so much time and thought on the medical group. It seems to me that this constitutes a lack of critical judgment on our part. We see our immediate problems and realize that they must have our attention, but we fail to take a long range view of the situation and to appreciate the underlying principles which govern our entire program. We must learn to be more patient, to extend our program only upon the advice and with the approval of the local medical group. We must learn to realize that in the long run our prob-

lems will be easier if we establish more firmly our cordial relations with the physician. If we will take the time to gain their confidence and coöperation, many of our seemingly pressing problems will be automatically taken care of, and we will find the way made smoother and easier for an ever widening, more complete and more effective public health nursing program.

[1]National Organization for Public Health Nursing. Survey of Public Health Nursing. The Commonwealth Fund. New York. 1934. Pp. 3, 8, 127-132.

[2]"Medical Relationships in Non-Official Public Health Nursing Agencies." PUBLIC HEALTH NURSING, November 1934.

[3]National Organization for Public Health Nursing. Manual of Public Health Nursing. The Macmillan Company. New York. Second edition, 1932. Pp. 9-10.

[4]Gardner, Mary S. Public Health Nursing. The Macmillan Company. New York. Third edition, 1936. Page 183.

*How an Official Public Health Nursing Agency Works with the Organized Medical Profession**

BY HELEN S. HARTLEY, R.N.

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THE evolution of working relationships between an official public health nursing staff and the organized medical profession is dependent upon the recognition of certain factors.

The official public health nursing staff is a part of an agency which carries on a specified health program for the territory where individual members of the medical society give professional services. The people are served by both the official agency and the private physician, and while the services are somewhat different, many opportunities arise for misunderstandings and misinterpretations. Also, the official agency has a more or less permanent, active executive while the officers of the medical society change fairly frequently and give comparatively little time to the cultivation of organization work. Therefore, the responsibility for the development of relationships rests more heavily upon the official agency.

A second consideration arises out of the fact that any relationship between two organizations must, in the last analysis, consist of the sum total of all relationships of individual members of one organization to individual members of the other. Given sound policies, successful administration of them is dependent upon the human element, and if the personnel of each organization has knowledge of the other's professional ideals and a sense of fair play, the status of relationships will be kept fairly constant.

In one community of approximately 100,000 population, a medical society of 10 members, and an official agency with a staff of 14 public health nurses, the following plan has been effective:

1. The official agency has a board of trustees. Two of the five members are physicians and members of the medical society.
2. When the official agency was first established, the medical society appointed (by request) a committee to act in an advisory capacity to the official agency.
3. Each public health service involving medical practices is begun with the understanding and coöperation of the advisory committee and the medical society.
4. Private physician's diagnoses of communicable disease are recognized by the official agency. When a public health nurse observes suspicious symptoms she reports her observations to the family physician directly or through the health officer.
5. The official agency offers public health nursing service to all physicians in the cause of health promotion, and assistance in arranging adequate care needed for their patients in lower economic levels.
6. The official agency offers biological supplies to all physicians to be used for nonpay patients.
7. Public health nurses take throat cultures of patients in all economic levels at the request of physicians. Also, other speci-

*Presented before the N.O.P.H.N. Round Table on Relationships—Medical and Social, Biennial Convention, Los Angeles, California, June 24, 1936.

mens are taken and public health laboratory service is offered all physicians for all non-pay patients and in some instances for pay patients.

8. Public health nurses respect the relationship of the patient to the private physician and are careful in referring persons for examination or treatment.

Perhaps one thing which brings to the attention of the physician the desire of the public health nurse to help him to help the patient is the referral note—a formally printed card on which the nurse fills in the name and address of the patient and the reason for referral, signing it with her own name and date.

In return, the official agency has found that:

1. Private physicians request consultation service from the agency's physicians and assistance from its public health nurses.
2. Physicians respond cordially to requests for assistance at the official agency health center or for care of patients referred by public health nurses.
3. Programs and procedures of the official agency have the approval of the medical society.
4. There is a friendly attitude in the medical society toward the official agency and on the part of the physicians toward the public health nurses.

BACK TO SCHOOL

Public health nurses will be interested in the following opportunities for study:

ADVANCED OBSTETRIC NURSING

The Maternity Center Association in coöperation with the Department of Nursing Education of Teachers' College announces an eight weeks' Maternity Institute for fifteen public health nurse supervisors beginning October 1, 1936. Classes will be held at Maternity Center Association headquarters.

National, state, and local aspects of maternity care will be presented. Obstetric lectures covering the factors which influence and affect the care of maternity patients will be given by an obstetrician. Special field observation will be arranged to meet the need of each student, in hospitals and in social and public health organizations in New York and its environs. Round table discussion will follow the field observations and the obstetric lectures. Also time will be allowed in each day for study.

The registration fee is $50.00. Students may live at Whittier Hall, a woman's dormitory of Teachers College, where the minimum cost for rooms and meals is $12.75 a week. To register for this Institute, write to the Maternity Center Association, 1 East 57 Street, New York, N. Y., giving your name, address and position held or reason for wanting to take this work, and an application blank will be mailed to you. Registration will be closed on September 15 or as soon as fifteen students are registered.

This unit will count for additional professional credit for students matriculated in the Department of Nursing Education at Teachers College.

WORK WITH THE HANDICAPPED

Teachers College, Columbia University is offering, in coöperation with other agencies, courses for persons who are now engaged in or who wish to prepare themselves for the work with handicapped. Some courses offered are planned to prepare teachers and other workers for the education of one type of the handicapped, while others cover problems common to all types of handicapped individuals. Field work will be offered also.

In order to encourage superior persons to make the necessary preparation for entering this field, a limited number of scholarships and teaching fellowships are available for 1936-1937. All inquiries should be addressed to Professor Merle E. Frampton, Office of the Secretary, Teachers College, New York, N. Y.

THE HONOR ROLL OF AGENCIES HOLDING 100% STAFF MEMBERSHIP IN THE N.O.P.H.N. WILL APPEAR NEXT MONTH

The Nurse in the High School*

By HAZEL FOELLER, R.N.

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PUBLIC health nursing has been an accepted program in our elementary schools since the latter part of the nineteenth century. However, a health program in the high schools is of recent origin, perhaps no older than ten years. For many years the need for a constructive follow-up program was felt in the high schools.

The present public health program begins with prenatal care and follows with health supervision through the infant, preschool, and grade-school periods, with a gap during the four years in high school when little or no attention is given to the care of the student's health. Too often the boy or girl goes on to college or into the business world with health handicaps that should have been discovered earlier, when preventive work could have been most effective.

Some eight years ago the Oregon State Tuberculosis Association financed a demonstration nursing service in a boys' trade high school in Portland, Oregon, for two years. This public health nurse was at first placed in the school primarily for first-aid work, both as a teacher of first-aid classes and to care for the considerable number of shop accidents occurring during school hours. This project proved itself so satisfactory that by the third year the board of education maintained the nursing service in that school as a permanent part of its set-up. In fact, the nurse's work in the school had taken on so many ramifications other than that of first-aid teaching that the tuberculosis association had the vision to sponsor a nursing service in two other high schools, the services of the nurse being divided between these two schools. The school department assumed the expense of this health program for the ensuing year; and at the present time it has a nursing service in seven of its ten high schools. Four high schools have a nurse for one day each week, two have a nurse two days each week, and one has a nurse four days each week. Much the same type of program is carried on in each school, with variations according to the needs presented.

Although the control of communicable disease receives a first consideration in any school program, the control of contagion in the high school is a minor part of the health program. This is due to two reasons: first, this age-group has acquired an immunity to most of the so-called "childhood diseases"; and second, the health education program in the elementary schools has carried over in regard to measures for preventing the spread of communicable disease—especially such conditions as the common cold and skin infections. An important control measure is the regulation that no student is admitted to school after being absent for three days without a health permit from either his family physician or—in case he has not been ill enough to have a physician—from the nurse.

As physical examinations are not compulsory in the schools of Oregon, all first-term students are offered this opportunity at the beginning of each school term. Permission for the examination must be signed by the parent or guardian of the student. In our schools about fifty per cent respond to this invitation, and it is from this physical examination that the nurse develops a constructive preventive and corrective program. Follow-up work to bring about improvements and corrections always means contacts with the home, the family physician, health agencies, and social agencies.

*Presented before the N.O.P.H.N. Round Table for School Nurses at the Biennial Convention, Los Angeles, California, June 24, 1936.

The health work in high school can be correlated nicely with the work of the science departments, as is done in one of our high schools. When the biology classes are studying the eye, the nurse does vision testing in the classroom, at which time a number of visual acuity defects have been discovered in upper classmen. While studying diphtheria, scarlet fever, and tuberculosis, the Schick, Dick, and Mantoux tests are made by the school physician. The physical education and the health programs are dovetailed; postural and foot defects found at the physical examinations and which do not require attention by an orthopedic specialist are referred to the gymnasium instructors for corrective exercises.

INDIVIDUAL TEACHING

Personal conferences with the high school students are a most important part of the nurses' work. While these are time-consuming and the results are sometimes difficult to measure, they are nevertheless a key to a wealth of valuable information in regard to the physical and emotional health of the students. These boys and girls have reached an age when their problems are serious questions to them and merit the nurse's careful and sympathetic consideration. Opportunities for teaching first-aid and many other health procedures, as well as instruction in regard to the anatomy and physiology of the body, are presented to the nurse when she is caring for injuries received at school, or listening to reports of bodily ailments.

Perhaps the most satisfactory results of our health program in the high schools come from the opportunities that arise in working with the student advisors. It is through this source that many referrals are made. Frequent absentees, those who show lack of attention in classes, some failing students, and those who appear to have vision difficulties are referred to the nurse as having possible health problems. It is also through her coöperative relationship with these deans of boys and deans of girls that the nurse becomes an integral part of the school.

In the case of the boy or girl who has taken advantage of the physical examination, defects are of course discovered by the examining physician and follow-up work by the family physician for correction is not so difficult to secure; but in cases of students who have not availed themselves of this examination and yet have such apparent handicaps as vision defects, loss of weight, overweight, and frequent colds, home contacts and follow-up work are somewhat of a problem. The problems of these students are discussed with the parents, and they are urged to take the children to their family physician or an eye specialist for a physical examination or an eye examination.

Athletic activities in high schools often have little or no correlation with the health program. Too often the athlete is chosen because of his willingness to participate in games, with no consideration given to his health as a whole.

Extra-curricular activities may be an important factor affecting the health of high school students. In one school with an enrollment of 1934 students there were thirty-six such organizations. Boys and girls carrying the full high school program have belonged to as many as four or five clubs, with no thought as to whether they were physically able to carry on all of these activities.

MENTAL HYGIENE

Mental hygiene is an important aspect of the health of the high school student, and students of this age-group have many problems with which the nurse is often brought in contact. Emotional upsets that come in the form of unhappiness in love affairs, anxiety over poor grades, disappointments of various kinds, and sickness used as a means of escape from school difficulties are some of the most outstanding situations. The high school student is many times misunderstood by his parents and other adults; and he sometimes finds in the nurse a friend in time of need.

The problem of menstrual disturbances is a common one with girls in the high schools. It is a common occurrence for girls to expect to be excused

from school at this time. If the nurse attempts to make inquiries about their general health habits, she is walking on very thin ice. Many girls are taught at home that their menstrual periods are necessarily a period of illness. An effort on the part of the nurse to get the advice of the family physician and the coöperation of the mother may help in building a more normal attitude toward this physiological function, as well as securing proper attention for those girls who have an abnormal condition needing medical care.

In order to meet certain definite needs in the program of health in the high schools and look toward the future when a more complete service will be carried on, it is suggested:

1. That the physical education and health departments work very closely together or under one head.
2. That physical examinations, including tuberculin skin tests and x-ray follow-up for reactors, be required for all new students—to be made by their family physician or the school physician.
3. That anatomy and physiology be placed in the curriculum, extending them over several terms, to be taught by persons with an adequate scientific background.
4. That all boys and girls entering competitive sports be given physical examinations.
5. That the nurse for the high school health service be carefully selected with regard to her qualifications for the position. In addition to being a well prepared public health nurse she should have an understanding of the problems of this age-group; should be equipped to teach and to counsel students; and should be well informed in regard to the aims, administration, and activities of secondary schools.

A high school functioning without a health program is like a wagon with one wheel missing. The need for education in regard to health is forcefully expressed by Will Durant, well known writer and philosopher of today: "First of all, and within the limits of nature and circumstance, I should want my children to acquire some control over the conditions of their lives. Since the primary condition of life and the strongest root of happiness is health, I should like to see them abundantly instructed in knowledge and care of their bodies . . . I should make the education in health a required course in every year of schooling from the kindergarten to Ph.D. I should want my children to learn as much about the structure and functioning, the care and healing, of their bodies, as can be taught in an hour a day for fifteen scholastic years."

*Durant, Will, "What Education Is of Most Worth," *Saturday Evening Post*, April 11, 1936.

Editor's note: We should like to emphasize the opportunities which the high school nurse has to be of service to the students through the school advisers or home-room teachers. The students who are referred to the nurse's personal attention are obviously a relatively few selected cases—those who have outstanding problems. All students have problems, however, and the home-room teacher is in a position to help with these because of her close contact with her immediate group. When the nurse aids the teacher by giving her scientific information which can in turn be used to meet the needs of the students, the nursing service reaches a much larger number of students indirectly than it is possible to reach personally.

Around the Table

Panel Discussion

THE N.O.P.H.N. panel discussion on the subject, "How Can the Community Provide Adequate Public Health Nursing Service?" provided one of the liveliest sessions of the Biennial Convention at Los Angeles, California. This general session on June 25, 1936, was attended by a large audience who sat with intense interest for three hours listening to the discussion between the group of lay, nursing and medical representatives on the platform.

It was felt that the panel served several useful functions, in addition to providing a very entertaining session: (1) It stimulated an open interchange of ideas by a body of representative lay and professional people who are concerned with public health nursing service in the community; (2) It demonstrated a technique for public information which may be used by local communities; (3) It brought out some of the problems and needs in public health nursing which are not being adequately met.

The following report covers some of the points of view advanced by participants in the panel and some high lights of the discussion, together with a summary of points brought out which are especially significant in relation to problems and trends in public health nursing.

The personnel of the panel, with the group represented by each of the members were:

Chairman: Alma C. Haupt, R.N., Director, Nursing Bureau, Welfare Division, Metropolitan Life Insurance Company, New York, N. Y.

Health officer: J. L. Pomeroy, M.D., Los Angeles County Health Officer, Los Angeles, Calif.

Board member, private agency: Mrs. Frederick S. Dellenbaugh, Jr., Secretary, Community Health Association, Boston, Mass.

Member of board of health: Joseph D. Minster, Commissioner, Department of Health, Los Angeles, Calif.

Superintendent of schools: A. R. Clifton, Los Angeles County Superintendent of Schools, Los Angeles, Calif.

Social worker: Zdenka Buben, Chief, Division of Medical Social Service, East Side Health and Welfare Center, County of Los Angeles, Los Angeles, Calif.

Member of family: Mrs. Budd Frankenfield, Vice-President, Children's Hospital Society, Los Angeles, Calif.

Private physician: Nadina Kavinoky, M.D., Los Angeles, Calif.

Public health nurse: Elnora Thomson, R.N., Director of Nursing Education, University of Oregon Medical School, Portland, Ore.

Community chest: Seward C. Simons, Executive Director, The Community Chest of Pasadena, Pasadena, Calif.

Agnes G. Talcott, presiding, opened the meeting and introduced the chairman. A series of nineteen slides showing various types of public health nursing activities were shown on the screen, with explanatory comments by Miss Haupt. She then announced the subject for consideration and started the discussion by asking Mr. Minster how he thought the community could provide adequate public health nursing service.

Mr. Minster praised the excellent work being done in public health nursing by tax-supported agencies, in the face of reduced budgets. He thinks that government agencies should not assume *too* much responsibility for the care of the people's health; that it is important for people to develop individual responsibility for their own health and welfare insofar as possible. He asked whether public health departments are receiving the support of the public, and especially of city governments, to the extent that they should. He cited as an example the city of Los Angeles, which spends 3½ cents of each tax dollar for public health, 38 cents for police protection, and 25 cents for fire protection. It has $400,000 a year less to use for health protection now than in 1929 and 1930.

Miss Haupt said that Mr. Minster apparently believes that health departments are offering the most efficient service possible with the resources provided them, and asked Mrs. Frankenfield if she agreed.

Mrs. Frankenfield said that families are greatly confused by the multiplicity of nursing agencies which serve them. She thinks this confusion should somehow be obviated. She believes that the nurse must have two things in order to do effective work: time and imagination. In addition, she should have *understanding*—which is not the same as sympathy.

Dr. Pomeroy said that public health owes a great deal to the public health nurse. He considers that it is better to analyze ourselves critically than to be satisfied with our accomplishments, and said that there are still many unmet needs. He gave as an example the fact that the tuberculosis rate—especially active tuberculosis in children—in the area served by his department has increased in recent years, and he deplored the large amount of money spent in institutions for cure, as compared with the small amount for prevention. He thinks that the nursing service is not adequately supported.

LAY PEOPLE AS INTERPRETERS

Mrs. Dellenbaugh said that the lay person connected with a nursing organization sometimes feels like a rubber stamp because so many of the problems are of a technical nature and require the decision of professional people. She believes that lay people have a definite responsibility as interpreters of the nursing service to the community, in order to secure community understanding and support so that the service can reach every home. Such interpretation is particularly important in relation to the group who are able to pay for nursing service, but who are often unaware of its availability. Also, the lay person represents the voting group, and should bring pressure to bear so that properly prepared people are selected for responsible positions. She considers that with the increase in nursing under public agencies the private agency should continue to be a pioneer in new fields.

Miss Haupt asked whether Mrs. Dellenbaugh's own community understands the work of its public health nursing service. Mrs. Dellenbaugh said "No," and that even the physicians do not fully understand it.

Miss Buben, in preparation for the panel, had called a conference of social workers and asked them whether they considered that the public health nursing service in their area is adequate to meet the needs as seen by the social worker. This group are aware that there is a multiplicity of agencies, all doing some form of public health nursing; but that there are also gaps in the service. For example: In the local area which they serve, one part of the community has no visiting nurse service, while another has a visiting nurse service limited in function. There is also a lack of finances for sufficient staffs. The hospital social workers stressed the fact that there are many cases sent in to the hospitals that could be cared for more cheaply at home.

Miss Buben said that fortunately the nursing profession realizes the lack of a complete, coördinated program and has secured a nursing section under the health division of the Council of Social Agencies.

Dr. Kavinoky urged the importance of better preparation of nurses. She said that the nurse has a much better understanding of the family than the physician, whose attention is focused on technical matters. Today, with psychological problems finding roots in the chemistry of the body, and rapid changes occurring in medicine, the public health nurse should have adequate preparation for her job. She should understand the problems of the family in order to help preserve the integrity of the family. She should be aware of the newer phases of mental hygiene.

Dr. Kavinoky stressed the need for planning together and coöperation between the medical and nursing profession. She said the nurse should be a liaison officer between the patient and the physician. The nurse knows the

need for adequate medical examination and care and can educate the patient to realize this need. A better understanding of the nurse's contribution is needed by the physician. Doctors who know about public health nursing appreciate it, but more physicians should be informed about it.

Mr. Clifton emphasized the importance of health in the field of education. He believes that the schools offer a strategic opportunity for health work because of the respect which the community has for the school administration. He thinks that the qualifications of the nurse should be as high as those of the teacher and should include: (1) educational preparation, (2) personality, (3) the right attitude.

Miss Haupt asked Mr. Clifton how he thinks the school nurse can function better.

Mr. Clifton said that the information secured in regard to home situations by the nurse is not always used to best advantage when brought back to the school. It is often merely filed away for her own use. He thinks the nurse should meet in case conferences with others of the faculty.

Mr. Simons said that public health authorities believe the contribution of public health in the future is the development and integration of the individual as a whole. He asked the question, "What is adequate public health nursing service?"—answering his own question by offering the opinion that standards vary. He believes that it is the function of groups such as lay boards and councils of social agencies to educate the community as to what constitutes a high standard of service.

PUBLIC UNDERSTANDING

Miss Haupt wondered how we can get *public understanding*, the importance of which had been emphasized by various members of the panel. She believes the answer is to develop an informed group who are intelligent regarding public health facts such as, for example, the cost of cure versus prevention in tuberculosis. She asked whether it is not the function of private agencies to bring about such an education of the public, laying particular emphasis on the preventive phases of social and health work.

She suggested that there may be danger in setting up water-tight compartments in regard to the respective functions of public and private agencies. She called attention to the function of private agencies in demonstrating the value of public health nursing services to the community; and said that the trend toward public agencies indicates that the value of the work has been proved to the taxpayers. She emphasized the importance of careful analysis regarding deficiencies and unmet needs.

Miss Thomson believes that many of the mistakes of public health nurses are due to their having been thrust into fields for which they were not adequately prepared. She thinks that the nurse formerly did not understand the social problems and implications in health situations; but that now she increasingly sees them yet often lacks the facilities for doing anything about them. Miss Thomson said that the problem in the urban field is primarily one of relationships; whereas in the rural field, there are certain special problems of the nurse working alone.

She agreed that physicians do not know our work but thinks it is our own fault; the nurses should make themselves known to the physicians. This is time-consuming, but worth the time it takes. She referred to the comment of Mr. Clifton that we tend to keep our information regarding families exclusively for our own use. She reviewed the purposes and uses of records, saying that they are primarily designed to make it possible for us to be of better service to the individual; and they can be profitably used by others who are also interested in that service.

She said it is imperative that the nurse know what she is talking about; that she must keep close to new knowledge in her field, because people do depend upon her a great deal. Understanding and sympathy must be made effective through knowledge. It is also

important that relationships with other workers be effectively established.

Miss Haupt said that apparently we have too many agencies and yet too few nurses to meet the needs. How, she asked, are we to get more nurses? Where can we get the money? Money is dependent upon public understanding. How shall we get public understanding? She suggested, as one method: community education through panels made up of community groups.

She stressed the importance of informing physicians in regard to public health nursing. Many physicians think that the nurse's bag carries medicines. [Why not try demonstrating the bag technique to the physician?] We should let the doctors know how many patients were referred to them by nurses; how many were not given nursing care because they were not under medical supervision.

Mr. Minster suggested that the time is coming when doctors will be paid to keep us well instead of getting us well. He emphasized the tremendous advances in preventive medicine and believes it is a trend of the times.

Miss Buben discussed how we can carry information over to the public. She said that their Council of Social Agencies includes a group of volunteers, lay people who are willing to give time and energy at no salary. The nursing section has laymen on it.

Dr. Kavinoky stressed the following points: (1) The nurse should interpret her work to the physician, especially by reporting carefully to him on his patients; (2) Laymen can interpret the community needs to the "city fathers"; (3) Mutual understanding and cooperation between the lay and professional groups are imperative. Isolation is not good for the professional groups.

Dr. Pomeroy thinks that preparing the nurse to have the same educational status as the teacher (as Mr. Clifton suggests) may result primarily in her copying the teacher regarding such things as hours of work and extended vacation periods, which may not be wholly desirable. He asked whether there is not danger of "over-education" of the nurse and whether her ability to put over a message is not more a gift than a product of education.

Mrs. Frankenfield said that she could not imagine anyone being over-educated. An individual may "act over-educated," but the more she knows the less misinformation she gives. (She gave an example of a so-called "practical nurse" who had once taken care of a patient in her family and had been completely uninhibited in regard to the giving of medical advice.) She stressed also that the nurse may be *educated in information but not in human relationships.*

Miss Thomson said that nursing education should be adapted to the needs of the time.

Dr. Kavinoky added that a Ph.D. degree cannot make up for a personality deficiency.

Mr. Clifton suggested that there is a difference between over-education and "mis-education."

Miss Haupt asked how we may help administrators to understand what should be expected of a good public health nurse.

Miss Buben suggested putting them on a nursing committee.

The point was made that school health services do not usually have nursing committees, but that there seems to be no reason why they should not have them.

Mr. Minster stressed the need for a highly trained publicity person to direct community education in regard to public health nursing.

SUMMARY

Miss Thomson closed the discussion and summarized some of the significant points which had been made. She said she felt very humble at the evidence of confidence placed in us as public health nurses.

Following is a summary of points brought out in the discussion:

1. There is need for a careful analysis of public health nursing services in relation to community needs.
   a. There are frequently a multiplicity of agencies offering services,

while at the same time there are gaps where unmet needs exist.
   b. The family is confused by the many agencies which serve it.
   c. Better coördination and planning are needed to secure a complete and integrated service.
2. More support from official funds is needed for nursing services.
   a. Community backing for this support depends upon the information of the public regarding the needs.
3. The respective functions of public and private agencies should be analyzed.
   a. With the increase in official agencies, the private agency will still be needed for experimentation, and demonstration of new services.
   b. The private agency has a special responsibility for education of the public.
4. Community understanding of public health nursing is vital to its effectiveness in meeting community needs.
   a. An informed lay group is essential to bring about community understanding.
   b. Interested lay people, especially board and committee members, have a responsibility for
      (1) Interpreting the service to the community.
      (2) Educating the community to a high standard of service.
      (3) Explaining the service which public health nursing has to offer to the middle class, who can afford to pay.
      (4) Interpreting c o m m u n i t y needs to those who make appropriations for public agencies.
      (5) Seeing that well prepared people are selected for responsible positions.
   c. A wider representation of interested lay people on boards and committees, health councils, and health sections of welfare councils is an effective means of community education.
5. Better understanding of public health nursing by the medical group is important. This will require:
   a. A closer working and planning together of physician and nurse.
   b. Adequate reports by the nurse to the physician on his cases.
   c. Perhaps the assistance of the lay group in interpreting the nursing service to the physician.
6. A close working relationship should exist between the nurse and other professional groups, such as teachers and social workers who have similar aims.
   a. Especially helpful for the school nurse are:
      (1) Coöperative planning with teachers.
      (2) A sharing of the information which the nurse obtains in the home with others who are interested in the child, especially through case conferences.
7. Adequate preparation of the public health nurse for her job is becoming increasingly essential in order that she may serve her patients better.
   a. Important qualifications are:
      (1) An understanding of the mental hygiene aspects of the work.
      (2) Skill in human relationships.
      (3) Imagination, understanding.
   b. School nurses should have as adequate preparation as the personnel in other school departments.
8. The nurse's part in meeting community needs is an important one, and she should learn to be more articulate and to speak for herself in groups where the nursing service is discussed.
9. Our work should tend to develop the responsibility of individuals and families in regard to their own health, and not make them too dependent on others.

The symposium "Motion Pictures as a Medium of Public Information" begun in the August issue will be continued in October.